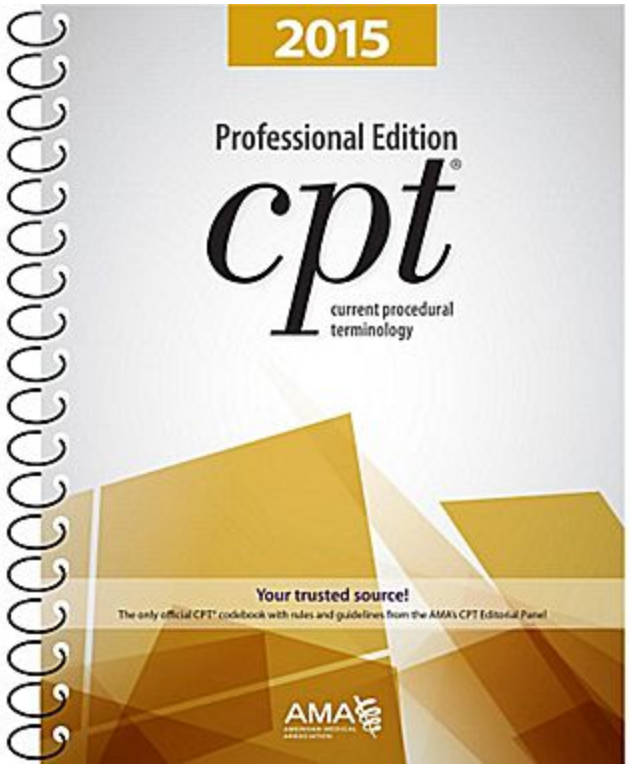
Office of Billing Compliance 2015 Coding, Billing and Documentation Program

Department of Pathology

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

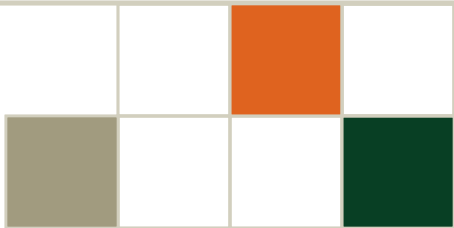
2015 Code Changes



UJHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM
UNIVERSITY OF MIAMI
MILLER SCHOOL of MEDICINE

Surgical Pathology Changes

- Some of the bigger changes include changes to immunohistochemistry IHC codes (88342, 88360 and 88361) as well as the ISH series of codes (88365, 88367 and 88368). As we have seen in previous years there will be revisions, deletions and additions to these code sets.



IHC and ISH

- Revisions clarifying the “per block,” “per slide” and “per specimen” issue.
  - The code descriptor for IHC and ISH will now include “per specimen” for each primary code.
- Second, each primary code will read, “initial single antibody procedure” for IHC and “initial single probe stain procedure” for ISH which leads to the addition of a new IHC add-on code for “each additional antibody stain procedure” and three new ISH add-on codes for “each additional single probe procedure,” one for qualitative results and two for quantitative/semi-quantitative; manual or computer-assisted.
- Third, CPT has added four new codes for IHC and ISH to report for multiplex procedures. The descriptor for these new codes will also include “per specimen.” These new codes will not be add-on codes and, per CPT there will be an either/or choice.
  - You will assign either the initial single procedure or you would assign the multiplex stain procedure.
- Last, code 88343 has been deleted for 2015 and replaced with 88341.

Immunohistochemistry (IHC) Code Changes – **Official** Language 2015

- 88342 Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure
- 88341 … each additional single antibody stain procedure (List separately in addition to code for primary procedure)
  - (Use 88341 in conjunction with 88342)

- 88344 …each multiple antibody stain procedure

Codes 88342, 88341 & 88344 pertain to *qualitative* IHC staining

- Two things that had not changed for both IHC and ISH will be whether the study is a qualitative versus quantitative/semi-quantitative result and whether the procedure is manual or computer-assisted. Overall the CPT changes for 2015 should clarify and simplify coding of these services.
- ***Note that some of the new codes will be out of numerical sequence and there have also been parenthetical revisions to keep in line with these changes.

Revised Code 88360/88361

2014:

- **88360** Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen, progesterone receptor), quantitative or semi-quantitative, *each antibody per specimen, each single antibody stain procedure; manual*
  88361 ……using computer-assisted technology

2015:

- **88360** Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen, progesterone receptor), quantitative or semi-quantitative, **per specimen,** each single antibody stain procedure; manual
- **88361** ……using computer-assisted technology

In situ Hybridization (ISH)

Revised code 88365

- **2014** In situ hybridization (eg, FISH), each probe
- **2015** In situ hybridization (eg, FISH), **per specimen; initial single probe stain procedure**

- **New Pathology Codes for 2015**
- **+88364** ……in situ hybridization (quantitative or semi-quantitative); **per specimen; each additional single probe stain procedure**
  (Use 88364 in conjunction with 88365)
- **88366** ……**each multiplex probe stain procedure**

Revised code 88367

- **2014** Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe, using computer-assisted technology
- **2015** Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, **per specimen**, **initial single probe stain procedure**

New Pathology Codes for 2015

- **+88373** ……each additional single probe stain procedure (Use 88373 in conjunction with 88367
- **88374** ……each multiplex probe stain procedure (Do not report 88367, 88374 in conjunction with 88365, 88366, 88368, 88377 for the same probe)

Revised code 88368

- **2014** Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe, manual
- **2015** Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual per specimen, **initial single probe stain procedure**

New Pathology Codes for 2015

- **+88369** ……each additional single probe stain procedure (Use 88369 in conjunction with 88368)
- **88377** ……each multiplex probe stain procedure (Do not report 88368 or 88377 in conjunction with 88365, 88367, 88374 for the same probe)

- Accurate selection and reporting of the ISH codes requires careful consideration of several key definitions and codebook instructions. The following principles apply to both the qualitative code family (88365 et seq.) and the quantitative/semi-quantitative code families (88367 et seq. and 88368 et seq.). Please note that these fundamental principles are valid and must be used in relation to all payers and patients, whether government (e.g., Medicare, Tricare) or private.

Fundamental Principles for Documentation and Coding for all payers (e.g., Medicare, or private.)

- 1. Focus on the specimen: The focus of the 88365, 88367 and 88368 ISH code families is on the specimen. Report the same ISH probe stain procedure no more than one time per any given specimen; however, the same ISH probe stain procedure applied to two different specimens may be reported twice.
- 2. Think 'procedure', not 'probe': The unit of service (i.e., charge) for all codes in the 88365, 88367 and 88368 families is the "probe stain *procedure*" (emphasis added by italics), not the probe itself. Some ISH procedures consist of a single probe, and in that instance, 'procedure' is equivalent to 'probe'. However, many ISH procedures involve two or more probes, and in that case, report one unit of service for the procedure as a whole irrespective of the number of probes that make up the procedure.
- 3. 'Multiplex' means multiple: As used in the context of codes 88366, 88374 and 88377, the term 'multiplex' refers to an ISH procedure that requires two or more probes to arrive at a single clinical conclusion. Multiplex ISH procedures typically accommodate the simultaneous analysis of all involved probes; that is, all the various color-coded signals are observable when looking through the microscope or at the image.

- 4. Never mix qualitative & quantitative for the same procedure: The qualitative ISH codes are separate and distinct from the quantitative/semi-quantitative ISH codes. It would never be appropriate to report both a qualitative code (e.g., 88365) together with a quantitative code (e.g., 88368) for the same ISH stain procedure. Of course, a code from each of two different families may correctly be reported for a specimen when two different ISH procedures are ordered and performed, or when each relates to a different specimen.
- 5. Reporting multiplex probe stain procedures per specimen: Report 88366, 88374 or 88377 as applicable for each *unduplicated* multiplex probe stain procedure for a given specimen. For example, three unique multiplex probe stain procedures on the same specimen will yield three units of 88366, 88374 or 88377 depending on the methodology.

- 6. Reporting single probe stain procedures per specimen: Report the first (initial) single probe stain procedure for a given specimen with code 88365, 88367 or 88368 as applicable.
  - (When two or more distinct single probe stain procedures are performed on one specimen, deciding which one is the 'initial' procedure is totally arbitrary.)
- 7. Report each additional *unduplicated* single probe procedure on that specimen with code 88364, 88373 or 88369 as applicable.
  - For example, three unique single probe stain procedures on the same specimen will yield one unit of 88365, 88367 or 88368 plus two units of 88364, 88373 or 88369.
- 8. Any given *initial* single probe stain procedure code (88365, 88367 or 88368) will be reported only one time per case, except when two or more specimens for the case each require evaluation by a single ISH probe stain procedure.
  - The code used to report the additional unduplicated single probe stain procedure(s) per specimen must always be of the same code family as the initial single probe stain procedure; for example, you would never report 88373 as the each additional code in conjunction with 88365 as the primary service code.

Question

- Is it proper for a pathologist to report a manual quantitative/semi-quantitative code (88368, 88369 or 88377) as a professional service if he/she doesn't personally perform the cell and probe signal counts (e.g., the counts are performed by a technologist who's trained in the ISH methodology).
  - The service does not require the physician to personally perform the service and it can be performed by a computer.
  - According to the AMA the role that must be played by a pathologist with the procedures consists of "first determining the appropriate areas of the tumor to evaluate," analyzing the cell and probe signal counts, "and then interpreting the [results]."
  - These are the inputs of the pathologist for which a professional fee is legitimately billable. Whether the pathologist additionally performs the cell and probe signal counts or leaves that up to a trained technologist or a computer isn't relevant.

Acceptable Documentation for ISH Testing

- When the report identifies:
  - the specimen(s) that's tested;
  - what the test is for (CMV, HPV, Her-2/neu, etc.);
  - the test method (FISH, CISH);
  - whether a qualitative or quantitative/semi-quantitative approach is taken to the test;
  - whether the morphometric analysis (if any) was done manually or with computer assistance; and
  - whether each probe stain procedure was single or multiplex.
- The best place to post ISH comment(s) from a charge support perspective is in the final diagnosis section of the report, either as part of the formal diagnosis of each applicable specimen or by "comment" subsection..

Prostate Needle Biopsy Code G0416

- CMS has determined that the "typical number of specimens evaluated for prostate [biopsy cases] is…10 to 12" and therefore deleted codes G0417 (*21-40 specimens*), G0418 (*…41-60 specimens*) and G0419 (*…greater than 60 specimens*) effective Jan. 1, 2015.
- CMS believes that prostate needle biopsy examinations require significantly less resources "as regards the number of blocks used to process the specimen and thus the amount of work involved" than the typical 88305-level specimen.
  - It asserts that to allow "CPT code 88305 to be reported in multiple units for prostate biopsies would account for significantly more resources than is appropriate."

  Starting 1/1/2015, only 1 unit of G0416 is to be reported per prostate needle biopsy case irrespective of the number of individual needle biopsies that are submitted for the Medicare patient by the referring physician.
- The descriptor for code G0416 is being revised to read *Surgical pathology, gross and microscopic examination for prostate needle biopsies, any method, 1 or more specimens*.

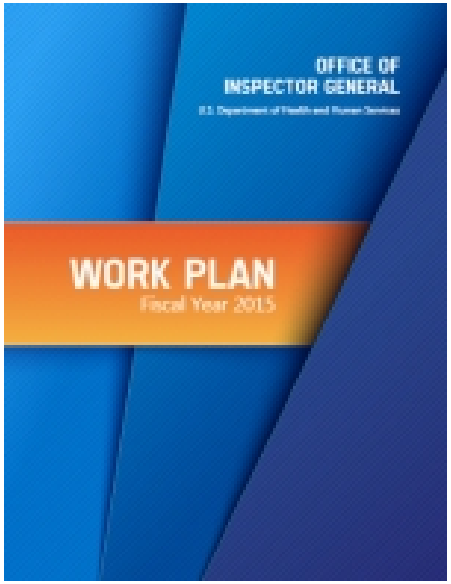
Molecular Pathology Changes

- Advances in DNA sequencing technology, commonly referred to as next generation sequencing (NGS) or massively parallel sequencing (MPS) are allowing the human genome to be analyzed in complex and diverse ways.
- Applications of this technology have resulted in new clinical diagnostic and in response to the changes in clinical practice and the need to provide a reporting mechanism for NGS or MPS procedures, the CPT code set has been expanded to include a new subsection for reporting these analyses, “Genomic Sequencing Procedures (GSPs) and other Molecular Multianalyte Assays.”
- This new subsection includes introductory guidelines which describe some of the characteristics of GSPs and other Molecular Multianalyte Assays including their unique features, functions and applications. The new subsection includes 21 new codes.

Documentation in the EHR - EMR

Volume of Documentation vs Medical Necessity

Annually OIG publishes it "targets" for the upcoming year. Included is EHR Focus and for practitioners could include:



Pre-populated Templates and Cutting/Pasting Documentation containing inaccurate or incomplete or not provided information in the medical record

- **REMEMBER:** More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the actual service provided on the DOS only.

General Principals of Documentation

- All documentation must be legible to all readers. Illegible documents are considered not medically necessary if it is useless to provide a continuum of care to a patient by all providers. Documentation is for the all individuals not just the author of the note.
- Per the Centers for Medicare and Medicaid services (CMS) practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
    - CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the date of service.
    - Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done, and this includes a signature.
- An addendum to a note should be dated and timed the day the information is added to the medical record and only contain information the practitioner has direct knowledge is true and accurate.

Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents Fellows and **Interns**

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill

UHealth UNIVERSITY OF MIAMI HEALTH SYSTEM | UNIVERSITY OF MIAMI MILLER SCHOOL of MEDICINE

Pathology Services

In the teaching setting the attending pathologist qualifies for reimbursement if:

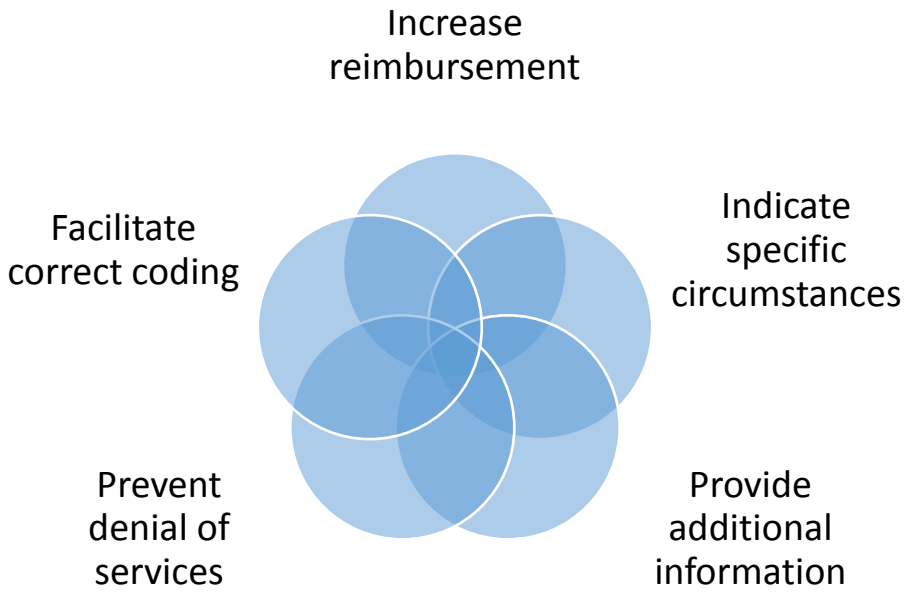
- The teaching physician's signature is the only signature on the report *(Carrier will assume that the author/attending is indicating that he or she personally performed the interpretation).*
- If a resident prepares and signs the report, the teaching physician must indicate that he or she has personally reviewed the specimen and the resident's interpretation and either agrees with it or edits the findings.
- Example: " I personally reviewed the specimen and agree with the final report".

In cases where the documentation shows simply a countersignature of the resident's interpretation by the teaching physician – no charges should be submitted by the attending physician

Modifiers: Provider Documentation MUST Support the Use of All Modifiers

A billing code **modifier** allows you to indicate that a procedure or service has been altered by some specific circumstance but has not changed in its definition.

Modifiers allow to:



When to Use Modifiers – To Bundle or Not

Bundled – verb: to collect or gather up into a mass (Oxford Dictionary)

- A **"bundled"** service includes all of the steps necessary to complete a given procedure.
  - Most CPT codes for procedures include additional CPT codes that are inherently part of a r procedure.
- **Unbundling** - occurs when 2 or more CPT codes are used to describe a service when a single, more comprehensive code exists that accurately describes the service performed.
  - "Bundled codes" can be "unbundled" to indicate that although they can be part of another procedure performed on the same date of service, for this encounter they should be paid separately.
- National Correct Coding Initiative (NCCI) edits provide most, but not all edits. Pre-billing "scrubber" checks for edits before billing.

Modifier 59: Distinct Procedural Service

- Designates instances when *distinct* and *separate multiple services* are provided to a patient on a single date of service and should be paid separately.
- Modifier-59 is defined for use in a wide variety of circumstances to identify:
  - Different encounters Different anatomic sites (Different services (Most commonly used and frequently incorrect).
- **4 new modifiers to define subsets of Modifier-59 in 2015**:
  - **XE - Separate Encounter**, a service that is distinct because it occurred during a separate encounter. Used infrequently and usually correct.
  - **XS - Separate Structure,** a service that is distinct because it was performed on a separate organ/structure. Less commonly used and can be problematic.
  - **XP – Separate Practitioner**, a service that is distinct because it was performed by a different practitioner.
  - **XU – Unusual non-overlapping service**, the use of a service that is distinct because it does not overlap usual components of the main service.

Modifier – 91 Repeat Clinical Diagnostic Laboratory Test

If an ordering physician requests a laboratory test that requires that several of the same services (CPT code) be performed for the same beneficiary on the same day, modifier -91 should be used to indicate that multiple clinical diagnostic laboratory tests were done on the same day. (This modifier should not be used when multiple tests are described under a single code, e.g., glucose tolerance test.)

Modifier GC
CMS Manual Part 3 - Claims Process - Transmittal 1723

- Teaching Physician Services That Meet the Requirement for Presence During the Key Portion of the Service when working with a resident or fellow

- Teaching Physician Services that are billed using this modifier are certifying that they have been present during the key portion of the service.

Coding Questions

- Can we bill for the use of the x-ray (CPT Code 76098) when the x-ray is used in diagnosing breast biopsies?
  - 76098 Radiological examination, surgical specimen

- *Radiological examination, surgical specimen*. The code accurately depicts what a pathologist may do in respect of a breast specimen and its associated mammogram or post-extraction film:

  - the pathologist reviews the x-ray to verify the orientation of the specimen and/or to confirm the precise location of a calcification deposit or lesion so that appropriate sections can be taken for microscopic evaluation. (This isn't the only time a pathologist might review a surgical specimen x-ray as an integral part of the sample's workup, but it's the most frequently encountered use.)

- The fact that 76098 resides in the radiology section of CPT doesn't prevent a pathologist from reporting the code when he or she performs the service, in accordance with the applicable AMA principle described in chapter 1 of this Handbook.

ICD-10

Looks like a go!

Diagnosis Coding
International Classification of Disease (ICD-10)

- ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
- ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
- ICD-10 CM will have 68,000 diagnosis codes and ICD-10 PCS will contain 76,000 procedure codes.
- This significant expansion in the number of diagnosis and procedure codes will result in major improvements including but not limited to:
  - Greater specificity including **laterality, severity of illness**
  - Significant improvement in coding for primary care encounters, external causes of injury, mental disorders, neoplasms, diabetes, injuries and preventative medicine.
  - Allow better capture of socio-economic conditions, family relationships, and lifestyle
  - Will better reflect current medical terminology and devices
  - Provide detailed descriptions of body parts
  - Provide detailed descriptions of methodology and approaches for procedures

Clinical Trials

Requirements for Billing Routine Costs for Clinical Trials

Effective for claims with dates of service on or after January 1, 2014 it is **mandatory** to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.

Professional

- For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (**do not use CT on the electronic claim, e.g., 12345678)** when a clinical trial claim includes:
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- **Modifier Q0** (investigational clinical service provided in a clinical research study that is in an approved clinical research study) and/or
- **Modifier Q1** (routine clinical service performed in a clinical research study that is in an approved clinical research study), as appropriate (outpatient claims only).

Hospital

- For hospital claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:
- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Items or services covered and paid by the sponsor may not be billed to the patient or patient's insurance, this is double billing.

WHO IS RESPONSIBLE FOR OBTAINING APPROVAL FROM THE MAC(S) FOR AN INVESTIGATIONAL DEVICE EXEMPTION (IDE) CLINICAL TRIAL?

- The principal investigator (PI) is responsible for assuring that all required approvals are obtained prior to the initiation of the clinical trial. For any clinical study involving an IDE, the PI must obtain approval for the IDE clinical trial from the Medicare Administrative Contractor (MAC) for Part A / Hospital.
- Additionally, for clinical studies involving an IDE, the PI is responsible for communicating about the trial and the IDE to the Medicare Part B (physician) MAC.
- Once approval has been received by the MAC, the following needs to take

place:

  - The Study must be entered in the Velos System within 48 hours.
  - The PI is responsible for ensuring that the IDE or the no charge device is properly set up in the facility charge master to allow accurate and compliant charging for that device before any billing will occur.

Investigational Device Exemption (IDE)

Hospital Inpatient Billing for Items and Services in Category B IDE Studies

- Payment for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved.

Routine Care Items and Services

- Hospital providers shall submit claims for the routine care items and services in Category B IDE studies approved by CMS (or its designated entity) and listed on the CMS Coverage Website, by billing according to the clinical trial billing instructions found in §69.6 of this chapter http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf, and as described under subsection D ("General Billing Requirements").

Investigational Device Exemption (IDE)

Category B Device. On a 0624 revenue code line, **institutional providers must bill the following for Category B IDE devices for which they incur a cost:**

- Category B IDE device HCPCS code, if applicable
- Appropriate HCPCS modifier
- Category B IDE number
- **Charges for the device billed as covered charges**
- If the Category B IDE device is provided at no cost, outpatient prospective payment system (OPPS) providers must report a token charge in the covered charge field along with the applicable HCPCS modifier (i.e., modifier – FB) appended to the procedure code that reports the service to furnish the device, in instances when claims processing edits require that certain devices be billed with their associated procedures. For more information on billing 'no cost items' under the OPPS, refer to chapter 4, §§20.6.9 and 61.3.1 of this manual.

WHEN THE TRIAL ENDS OR REACHES FULL ENROLLMENT?

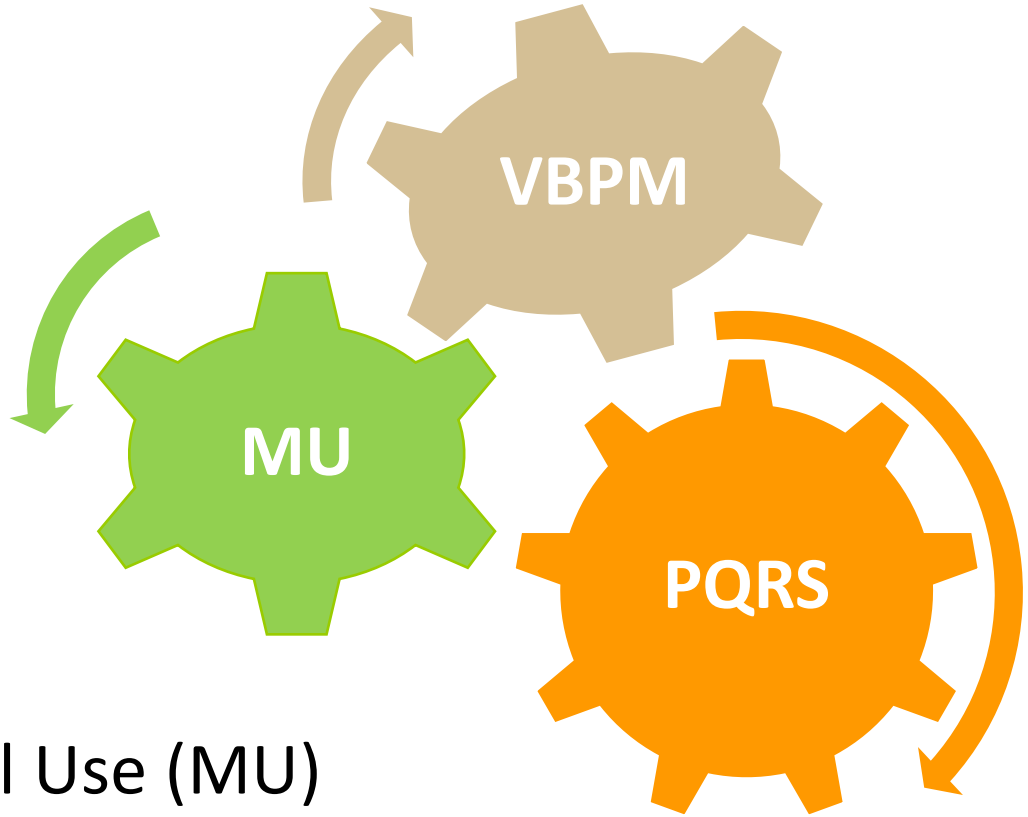
When the trial ends, whether due to reaching full enrollment or for any other reason, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the item in the charge master so that it may no longer be used.

If the device is approved by the FDA and is no longer considered investigational or a Humanitarian Device Exemption (HDE) and will continue to be used at UHealth, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the investigational device in the charge master and to ensure that a new charge code is built for the approved device. At this point, ongoing maintenance responsibility would transfer to the relevant Revenue Integrity Office (s).

UHealth/UMMG
2015 PQRS

Patient Safety and Quality Office

CMS Quality Improvement Programs



- ✓Meaningful Use (MU)
- ✓Physician Quality Reporting System (PQRS)
- ✓Value Based Payment Modifier (VBPM)

CMS Quality Programs
Medicare Part B Payment Reductions

PROGRAM	POTENTIAL MEDICARE PAYMENT REDUCTION					
	2015	2016	2017	2018	2019	2020
Meaningful Use	1%	2%	3%	4%	5%	5%
PQRS	1.5%	2%	2%	2%	2%	2%
VBPM		4%	4%	4%	4%	4%
TOTAL PENALTIES	**2.5%**	**8%**	**9%**	**10%**	**11%**	**11%**

2015 PQRS Eligible Providers

Physicians	Practitioners	Therapists
MD	Physician Assistant	Physical Therapist
DO	Nurse Practitioner	Occupational Therapist
Doctor of Podiatric	Clinical Nurse Specialist*	Qualified Speech-Language Therapist
Doctor of Optometry	CRNA	
DDS	Certified Nurse Midwife	
DMD	Clinical Social Worker	
Doctor of Chiropractic	Clinical Psychologist	
	Registered Dietician	
	Nutrition Professional	
	Audiologists	

PQRS

- Reporting Requirements:
  - ✓Reporting Period= Full CY
  - ✓Report **9** Measures from **3** National Quality Strategy Domains

- Reporting Options:
  - Claims, EHR, **Registry**
    - Individual or GPRO

NATIONAL STRATEGY DOMAINS					
Communication & Care Coordination	Effective Clinical Care	Efficiency & Cost Reduction	Patient Safety	Person & Caregiver-Centered Experience & Outcomes	Community/ Population Health

Physician Impact

Workflow and documentation changes

TO DO:

✓Study Measure Specifications

✓Ensure documentation meets measure requirements

✓Bill PQRS quality code when required in MCSL/UChart

✓Document chronic conditions/secondary diagnoses

✓Use UChart Smart Phrases

✓Ensure medical support staff completes required documentation

PQRS For Pathology 2015

- This program, like the others, provides incentive payments and negative payment adjustments to promote reporting of quality information for covered professional services.
- Eligible practitioners and group practices who successfully report quality information can receive an incentive payment of 0.5 percent of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during that same reporting period.

- In 2015, the PQRS will begin adjusting payments for those providers who **do not** satisfactorily report data, reducing allowed charges by 1.5 percent for 2015 and 2.0 percent for 2016 and subsequent years.
- Reporting requirements require eligible practitioner and group practices to report on at least one valid measure.
- 5 PQRS Measures Developed by the College of American Pathologists, Endorsed by the American Society for Clinical Pathology and approved by CMS.

Current Pathology Measures

- **Breast Cancer Resection Pathology Reporting:** Measure #99 – pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
- **Colorectal Cancer Resection Pathology Reporting:** Measure #100 – pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
- **Barrett's Esophagus:** Measure #249 – Esophageal biopsies with a diagnosis of Barrett's esophagus that also include a statement on dysplasia
- **Radical Prostatectomy Pathology Reporting:** Measure #250– Reports include the pT category, the pN category, the Gleason score and a statement about margin status
- **Immunohistochemical (IHC) Evaluation of HER2 for Breast Cancer Patients:** Measure #251 – Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines

In addition, several other measures, developed by CAP and endorsed by ASCP, are currently under development and/or review. These measures have not yet been approved. ASCP is hopeful that these or other measures will soon be available for use.

- **Proposed New Measure #1 – Lung cancer reporting (biopsy/cytology specimens)**
- Pathology reports based on biopsy and/or cytology specimens with a diagnosis of non small cell lung cancer classified into specific histologic type or classified as NSCLC-NOS with an explanation included in the pathology report.
- **Proposed New Measure #2 – Lung cancer reporting (resection specimens)**
- Pathology reports based on resection specimens with a diagnosis of primary lung carcinoma that include the pT category, pN category and for non small cell lung cancer, histologic type.
- **Proposed New Measure #3 – Melanoma reporting**
- Pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate.

HIPAA, HITECH, PRIVACY AND SECURITY

- **HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA**
  - Protect the privacy of a patient's personal health information
  - Access information for business purposes only and only the records you need to complete your work.
  - Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  - **PHI is protected even after a patient's death!!!**

- **Never share your password with anyone and no one use someone else's password for any reason, ever –even if instructed to do so.**

✓If asked to share a password, report immediately.
✓If you haven't completed the HIPAA Privacy & Security Awareness on-line CBL
✓module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/

HIPAA, HITECH, PRIVACY AND SECURITY

- **HIPAA, HITECH, Privacy & Security**
- Several breaches were discovered at the University of Miami, one of which has resulted in
- a class action suit. As a result, **"Fair Warning"** was implemented.
- **What is Fair Warning?**
- • **Fair Warning** is a system that protects patient privacy in the Electronic Health Record
- by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
- • **Fair Warning** protects against identity theft, fraud and other crimes that compromise
- patient confidentiality and protects the institution against legal actions.
- • **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA
- auditing.
- UHealth has policies and procedures that serve to protect patient information (PHI) in
- oral, written, and electronic form. These are available on the Office of HIPAA Privacy &
- Security website: http://www.med.miami.edu/hipaa

Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - ***Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or***
  - ***Iliana De La Cruz, RMC, Director Office of Billing Compliance***
    - ***Phone: (305) 243-5842***
    - **Officeofbillingcompliance@med.miami.edu**

- Also available is The University's fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24hours a day, seven days a week).
- Office of billing Compliance website: **www.obc.med.miami.edu**

QUESTIONS