

UMDNJ-Office of Ethics & Compliance

Compliance Counts!

**UMDNJ**
UNIVERSITY OF MEDICINE &
DENTISTRY OF NEW JERSEY

Message From Kathy VanCamp

Acting Executive Director

Medicare and Medicaid billing. Meticulous record-keeping. Detailed government regulations. If a healthcare institution gets any of these wrong, it exposes itself to government scrutiny and oversight and, possibly, large fines. The job of the Office of Ethics and Compliance is to make sure the institution gets it right.

Initiatives for 2009:

- Supplemental Code of Ethics
- Records Management
- Updated Compliance Education Training
- Development of Metrics for Success
- Conflicts of Interest
- Updated Code of Conduct

In 2005, the Federal government published an updated version of a lengthy document known as the Federal Sentencing Guidelines which intended to outline, with some measure of certainty, the types of punishments to be meted out to organizations, based on certain types of criminal behaviors. It is this document that outlines the fundamental requirements of an “effective compliance program.”

In Chapter 8 – Part B of these guidelines, the concept is introduced as to how organizations can “remedy harm from criminal conduct” by implementing effective compliance and ethics programs. In evaluating punishment of organizations that have been convicted of Federal crimes, sentencing takes into consideration whether or not the organization has a compliance program in place.

These guidelines form the basis of the Compliance Program at UMDNJ today. At a minimum, there are 7 steps in an effective compliance program as outlined in 2005. These steps are:

- The organization shall establish policies, procedures and standards of conduct.
- The organization shall appoint a Compliance Officer and a Compliance Committee.
- The Compliance Office shall conduct effective training and education.
- The Compliance Office shall develop effective lines of communication, including ways to report suspected problems anonymously.
- The Compliance Office shall conduct internal audits and ongoing monitoring.
- The Compliance Office shall respond promptly to detected offenses and develop corrective action related to such offenses.
- The Compliance Office shall enforce standards of behavior through well publicized disciplinary guidelines.

Some might argue today that there is actually an 8th step in an effective compliance program which would include:

- The Compliance Office shall conduct on-going risk assessment to evaluate the elements of risk inherent in the organization.

At UMDNJ, each of these elements is evident in our schools and hospitals. Compliance Officers have been appointed, education and training is ongoing, audits and monitoring are conducted as outlined in our annual workplan, the Ethics Helpline (800-215-9664) allows for anonymous reporting of concerns, and discipline is carried out according to guidelines.

Effective compliance programs are not meant to replace solid operations and management in any organization. Its role is to assist, to support and to aide an organization in becoming the most effective and compliant organization it can become.

Enjoy the newsletter!

Kathy VanCamp
Acting Executive Director
Office of Ethics & Compliance

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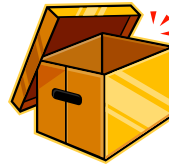
Record Retention News

Great News!! The University finally has received approval from the U.S. Attorneys Office for the University to implement its Board approved policy to retain and destroy documents in accordance with State and Federal guidelines.

So what does this mean to you? In short this means...

To shred documents, you must do the following:

- 1) Separate records from non-records.
- 2) Non-records must be audited before they are shredded.
- 3) Records may not be shred until the destruction is approved by the NJ Department Archives and Records Management (DARM).



If you have not already done so, do the following:

- Read and follow the University's policy, which is posted, on the Office of Policy & Project Management's website:
http://www.umdnj.edu/oppmweb/university_policies/administration/PDF/00-01-10-50_00.pdf
- Follow the audit procedures prior to shredding non-records (follow instructions on the Office of Ethics and Compliance; Records Retention link)
<http://www.umdnj.edu/complweb/record/index.htm>
- Contact your Records Liaison to assist you in setting up a records management program.
<http://www.umdnj.edu/complweb/record/liaisons/index.htm>
- Coordinate with your Records Liaison, Contract Management Department, 732-235-9531 and Purchasing Service, 732-235-9089 to coordinate with an outside vendor to shred your non-records holding after audit and to set up your purchase orders.
- Contact Data Control if you did not receive your department's list of archive stored at Logical Source. Review the documents in archive to determine if they have met the retention schedule requirements and complete DARM's "Request and Authorization for Records Disposal" Forms prior to destruction (follow the recommended process).



Transition to Highmark Medicare Services

On November 14, 2008, New Jersey transitioned to a new A/B MAC. A/B MAC refers to Part A claims, Part B claims and Medicare Authorized Contractor. A/B MAC's take the place of FI's (fiscal intermediaries), who processed Part A claims, and Local Carriers, who processed Part B claims. The intention of this transition was to bridge the gap between the previously separate entities that held the contracts to process Part A and Part B claims and to streamline claims processing.

The U.S. is now broken into 14 jurisdictions. Jurisdiction 12, or J12, consists of New Jersey, Pennsylvania, Delaware, Maryland, and the metropolitan area of D.C. The contract for J12 was awarded to Highmark Medicare Services (HMS). The effective dates for the transitions of the States under J12 varied to ensure each was transitioned completely and effectively before moving to the next State. Again, NJ was transitioned on 11/14/08.

CMS allows its claims contractors to define carrier specific policies, provided they are not less restrictive than current CMS guidelines. This allows each A/B MAC the authority to define and impose policies and procedures of their own.

Highmark Medicare Services (HMS) has some significant differences from our previous carrier, National Government Services, formerly Empire Medicare. The differences are as follows:

- Updates to Claims Processing Rules – Attachments
- E/M 1995 Guidelines: HPI in History
- E/M 1995 Guidelines: Definition of a Detailed Exam
- E/M 1995 Guidelines: Body Areas vs. Organ Systems
- Consultations
- New LCD's
- Category III codes ("T" codes)
- CERT probes
- Carrier priced codes

Updates to Claims Processing Rules – Attachments

When submitting claims that require an attachment on the initial submission, a new process is required. If possible, use the “claims note segment”, or the equivalent to box 19. For claims which require information that cannot be listed in the “claims note segment”, it is required that the information be submitted at least 7 (seven) days prior to the claim being filed. This would happen, for example, when submitting notes for an unlisted code (99499) or supporting documentation for claims with modifier 22 (increased procedural services) or 62 (two surgeons).

A form must accompany the notes submitted, called a “Cover Sheet for Submitting Medical Documentation for Electronic Claims”. Information for only one patient may be utilized per cover sheet. The cover sheet must list the Patient name, HICN, DOS, NPI, and PTAN (Provider Transaction Access Number).

An indicator will need to be used in the electronic claim submission. This indicator will prompt HMS to match up the paper documentation submission to the electronic claim submission prior to processing. This is achieved by selecting the appropriate “report type code”, selecting the “by mail” option, entering “AC” in the identification code qualifier, and reporting the “attachment control number” as the Identification Code.

E/M 1995 Guidelines: HPI in History

The History of Present Illness is one of three components in History. There are two levels of HPI, brief and extended. A brief HPI requires 1-3 elements while an extended HPI requires at 4 or more elements be documented (or indication of the status of 3 or more chronic conditions). Elements include Location, Quality, Severity, Duration, Timing, Context, Modifying Factors and Associate Signs and Symptoms. HMS has indicated that if the same element is documented for multiple problems, this may not constitute an Extended HPI. Example: At the same visit, location is documented for a chief complaint of leg pain and location is documented for a chief complaint of rash. This cannot be counted as 2 elements of HPI, since only 1, location, was used. Additional descriptors would need to be documented to attain higher levels of HPI.

E/M 1995 Guidelines: Definition of a Detailed Exam in the 1995 E/M Guidelines

The interpretation of a detailed examination was the change with the most significant provider impact. Dr. Bloschichak, the Medical Director of HMS, along with outside reference, has determined that a detailed examination requires at least 4 body areas or organ systems be documented, and that each of these have at least 4 items documented in each. This is commonly referred to as the “4x4 rule”.

Example: *Constitutional*: BP 120/80, Temp 97.6, Pulse 72, Wt 165 lbs *Respiratory*: CTA, No rhonchi, No rales, Non-labored breathing *Cardiovascular*: Regular rate and rhythm, No murmurs, No rubs, No gallops *Neurological*: DTR’s normal, Sensation normal, Coordination normal, CN’s 3, 4 & 6 normal.

If you have less than the “4x4” required, it would be subject to the clinical judgment of the claims reviewer. The Medical Director does not review claims deemed to be deficient in this based on clinical judgment.

It may be beneficial to review the 1997 E/M Guidelines for Examination. Here, a detailed examination required documentation of at least 12 “bullets”. The important difference between these sets of guidelines is that the “bullets” are pre-defined in the 97 set, while in the 95 set they remain undefined.

E/M 1995 Guidelines: Body Areas vs. Organ Systems

In the HMS Online FAQ’s, it is stated that “you may count up to 7 body areas or 7 organ systems for an expanded problem focused or detailed examination... however, you may not add body areas and organ systems together to determine a level of the examination”. If elements are documented in both areas and systems, only 1 (either areas or systems) will be counted when determining a level of examination for Expanded Problem Focused and Detailed examinations. HMS has adjusted how a body area/organ system will be allocated based on frequent intermingling. For Gastrointestinal vs. Abdominal, HMS will allocate the elements for GI and Abdominal to each if there is a co-mingling of elements in the documentation. Example: *Abdomen soft, non-tender and non-distended, positive BS, no hepatosplenomegaly*. In this example, credit for 4 elements will be applied to GI and to Abdominal. When calculating the final level of examination, whichever one element (either body area of Abdomen or organ system of Gastroenterology) is applicable will be counted.

Consultations

To help clarify the requirements of consultations, HMS has identified some additional requirements for the Request portion of Consultations. HMS has indicated that a “written request for consultations shall be kept in the patient’s chart” and that while a “verbal request is allowable” provided it is documented in the patient’s chart by both the requesting and rendering providers, this “should be the exception and not the rule”. The second clarification is focused on who can request a consultation service. A consultation may be requested by a Provider or Other Appropriate Source, according to CMS. HMS has defined the term “Other Appropriate Source” to mean one “who has enrolled in the Medicare program and (has) obtained an individual NPI for reporting purposes.” If you have been accepting requests from, for example, the judiciary system, a school system or a non-healthcare facility, you may not bill these services as consultations under the HMS guidelines.

New Local Coverage Determinations (LCD’s)

HMS has 57 LCD policies. Of which, 3 policies expand on a NCD’s (National Coverage Determinations by CMS) with coding information added. These are Bone Mass Measurements, PET Scans and Immunizations. All LCD’s are effective as of the cutover date with no “grace period”. If no LCD exists for a service, check CMS for a NCD. If no NCD exists, “Reasonable and Necessary” guidelines apply.

LCD’s of interest include:

- Blood glucose monitoring in a nursing home
- Cardiovascular stress testing
- Consultations
- Coverage of services and procedures in the nursing home
- Routine foot care
- Electrocardiography
- E/M services in a nursing home
- Paravertebral facet joint nerve block and Sacroiliac injection
- PM&R services, including PT and OT services
- Psychiatric therapeutic services
- Removal of impacted cerumen
- Speech / Language Pathology
- Treatment of varicose veins of the lower extremities
- Trigger point injections
- Wound care
- Acute care: inpatient, observation and treatment room services



Transition to Highmark Medicare Services - Continued

Category III codes (“T” codes)

HMS will cover all Category III codes, known also as “T” codes or “Cat III” codes. T codes are temporary codes use to identify emerging technology, services and procedures. T codes are used in lieu of an unlisted Category I code (00100-99607). The use of T codes allows health care professionals, as well as insurers, researchers and health experts to identify new and emerging technology, services and procedures for clinical efficacy, utilization and outcomes. T code use can influence future Category I codes, as they may be later included in the main body of the CPT book as a permanent code if use indicates a need. An example of a Category III “T” code is 0066T, Computed Tomographic (CT) colonography (i.e. virtual colonoscopy); screening.

CERT’s (Comprehensive Error Rate Testing)

HMS will conduct CERT (comprehensive error rate testing) probes based on GPRA (Government Performance and Results Act) findings. These will be managed by HMS and Advance Med, an outside contractor. Findings will be categorized by specialty, procedures and locale. If findings result in a determination of under-coding, additional monies will be paid for the difference in level of service fees. NJ is 3rd in the country for error rates, with a National Average error rate of 4.50%, as of May 2008, NJ is 7.30%!

CERT findings and areas of interest:

- E/M services
 - Consultations (especially inpatient level 4 and 5)
 - Subsequent office visits (especially 99214)
 - Hospital visits, including Discharge (time separates 99238 from 99239)
 - Emergency visits
 - Nursing home visits
- Therapies
 - PT/OT
 - Chiropractic services
- Diagnostic studies (-26) need “interpretation and report”
- Date of Service (NEW ISSUE!)



HMS has recommended that all claims denied by the CERT (or RAC) for clerical errors (e.g. incorrect date of service entered on charge) be appealed. If your documentation is illegible, review and/or transcribe prior to sending. Medical review is requested by an “ADR” (Additional Documentation Request). These can be pre- or post-payment. The most common is pre-payment where 20-30 claims are reviewed before payment is released. If you are assigned a specific review nurse, it is a provider specific review, as opposed to a service specific review. **INFORM COMPLIANCE IF THIS OCCURS!**

Carrier Priced Codes

New fees will be determined for Contractor priced codes on an individual basis after review of the procedure documentation by the Medical Director. Contractor priced codes can be identified by the status “C” on the MPFSDB (Medicare Physician Fee Schedule Data Base).

By:
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Questions? Call Colleen at 856-566-6410 or email her at wadeca@umdnj.edu.

If you have any news that you would like included in the newsletter, please forward to:

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Coding Tip Of The Day

New From Highmark Medicare Services

Effective March 1, 2009

- To authenticate a call, have ready
- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last 5 digits of Tax Identification Number

CMS is also requiring the same information for written correspondence.

- All correspondence must be on provider specific letterhead.
- You can no longer send information on blank paper.



Thank You to Deborah Samuels
for providing our
Coding Tip Of The Day!