2018 2nd Quarter
Volume 12, Issue 2

Compliance Quarterly

From the Compliance Office...

Upcoming: 3rd Quarter Fraud, Waste & Abuse Training Newsletter

Please be aware that the next newsletter, 3rd Quarter 2018, will be the Annual Fraud, Waste & Abuse Training that all UBMD personnel are required to complete.

Newsletter Topics

In the *Compliance Quarterly,* we focus on currently relevant Compliance & HIPAA topics, regulatory updates, and helpful tips.

If anyone has a topic you would like to see covered, general or practice-focused, in a future edition of *Compliance Quarterly,* please contact Sue Marasi (smmarasi@buffalo.edu).

Compliance Training Update

New Provider E/M & Documentation Training

This is a one session training class. All are welcome to attend any of the sessions. It's also a good refresher for the not-so-new providers! ***Please contact Bev if you would like to attend a session so that she can be sure to have enough materials for all attendees.***

Location & Time: 77 Goodell St., Room 310F, 11:30AM

2018 Dates:

September 11 & 25	October 9 & 23
November 6 & 20	December 4 & 18

Lunch-n-Learn

Sessions are usually held once a month. Bring your lunch, and join us as we cover a variety of important topics related to coding and compliance! AAPC & AHIMA CEUs are often available for the sessions. All are welcome to attend. ***If you would like to be added to the session contact list, please contact Bev as noted to the right.***

Location & Time: 77 Goodell St., Room 205, 12:00-1:00PM

2018 Dates: 9/18, 10/16, 11/13 & 12/11

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Training Questions:

If you have questions on any the training, please contact Bev Welshans by telephone (888-4702) or e-mail: welshans@buffalo.edu

Proposed Evaluation & Management Changes for 2019

By: Beverly Welshans, CHC, CPMA, CPC, COC, CPCI, CCSP

Although we are only half way through 2018, CMS is already hard at work on the 2019 Physician Fee Schedule. Early data being distributed promises sweeping changes in the E/M codes and supporting documentation. Recent notifications from CMS preview some of the changes, and I think the changes will be welcomed by providers. From what I have seen so far, CMS is accurately echoing the concerns and frustration that I hear from providers every day.

The Coding Corner

The following is an excerpt from the July 17, 2018 A Letter to Doctors from CMS Administrator Seema Verma.

"CMS is committed to turning the tide. President Trump has made it clear that he wants all agencies to cut the red tape, and CMS is no exception. Last year, we launched our "Patients over Paperwork" initiative, under which we have been working to reduce the burden of unnecessary rules and requirements. As part of this effort, we have proposed an overhaul of the Evaluation & Management (E&M) documentation and coding system to dramatically reduce the amount of time you have to spend inputting unnecessary information into your patients' records. E&M visits make up 40 percent of all charges for Medicare physician payment, so changes to the documentation requirements for these codes would have wide-reaching impact.

The current system of codes includes 5 levels for office visits – level 1 is primarily used by nonphysician practitioners, while physicians and other practitioners use levels 2-5. The differences between levels 2-5 can be difficult to discern, as each level has unique documentation requirements that are time-consuming and confusing.

We've proposed to move from a system with separate documentation requirements for each of the 4 levels that physicians use to a system with just one set of requirements, and one payment level each for new and established patients. Most specialties would see changes in their overall Medicare payments in the range of 1-2 percent up or down from this policy, but we believe that any small negative payment adjustments would be outweighed by the significant reduction in documentation burden. If you add up the amount of time saved for clinicians across America in one year from our proposal, it would come to more than 500 years of additional time available for patient care."

CMS is currently in a 60-day comment period allowing anyone to share their thoughts, concerns or questions about the proposed changes. I have included two links below that can provide you with additional information.

If enacted, these changes will significantly reduce administrative burdens on providers and improve patient care.

https://www.youtube.com/watch?v=W2QBTQNxfSY&feature=youtu.be

https://www.youtube.com/watch?v=JvoRQfMtPo4

General Compliance: Healthcare's Role in Human Trafficking

By: Sue Marasi, CHC, CPCA, Compliance Administrator

Human trafficking may not be something that crosses our minds on a regular basis, but it probably should be. It's more common than many of us may realize, and healthcare professionals are in a unique position to identify victims of human trafficking.

First, some background information. Human trafficking has been reported in all 50 states. New York State is one of the top 4 trafficking destinations, behind California, Florida and Washington, DC.

According to the New York State Attorney General's Office, the United States is a "source, transit and destination country for men, women, and children subjected to forced labor, debt bondage, document servitude, and sex trafficking," with the majority of trafficked adults and children (U.S. citizens) being trafficked in the commercial sex industry. In 2017, the National Human Trafficking Hotline (NHTH) reported 333 human trafficking cases reported in New York State—238 sex trafficking, 53 labor trafficking, 21 unspecified, and 21 both sex and labor. Remember, that is only *reported* cases. The majority of trafficking cases go unreported.

On a more local level, a 1/17/18 report on WKBW News stated that there have been 1,200 human trafficking cases in Western New York over the past 10 years, ranging in ages 9-81, and categorized as either sex or labor trafficking. The report also stated that, according to the Erie County Sheriff's Office, there were 96 trafficking cases reported in 2016 in Western New York, of which more than half were sex trafficking cases. 60 of those of those 96 victims were children.

So what can we, in the healthcare industry, do? What is our role? Let's look at a few more eye-opening statistics before we get some answers to those questions.

"...96 trafficking cases reported in 2016 in WNY.....60 of those were children. "

- According to the National Human Trafficking Resource Center (NHTRC), one study showed that 87.8% of trafficking survivors reported accessing healthcare services during their trafficking situation. Of this, 68.3% were seen at an emergency department.
- Research has shown that 10% of doctors recognize trafficking victims, and less than 3% of ER doctors have received training in recognition and action.
- A 2017 survey report from the Coalition to Abolish Slavery & Trafficking (CAST) found that over half of labor and sex trafficking victims surveyed had accessed health care at least once while being trafficked. Nearly 97% indicated they had never been provided with information or resources about human trafficking while visiting the health care provider.

Healthcare providers and staff need to be able to recognize possible trafficking victims. Most victims will not readily announce that they are victims. Quite the opposite. According to the NYS Attorney General's Office, "Trafficked victims often do not see themselves as victims. They may even blame themselves as a result of the severe manipulation of their traffickers. Victims often are told not to trust law enforcement and may have even been violated or punished by police in the past. Victims often have been trained and manipulated into believing that there is no way out and no one who can help them, especially if they are undocumented." Out of shame or guilt, they will not identify themselves as victims. Additionally, victims may fear retaliation by the trafficker, or arrest or deportation.

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Who, then, do we look for; who are typical victims? The truth is, anyone can be trafficked. Persons of any age, gender or economic status can become victims. Traffickers will usually target vulnerable individuals who are easier to recruit and control. The most commonly preyed upon are undocumented migrants, runaways, at-risk youth, and oppressed or marginalized groups.

> ***"That which is measured improves. That which is measured and reported improves exponentially."***
>
> *~ Karl Pearson, Mathematician*

According to the NHTRC, victims seek medical services in emergency medical situations, as well as:

- After an assault or workplace injury;
- For gynecological services and prenatal care;
- For routine check-ups;
- For mental health services and addiction treatment;
- For pre-existing conditions or health issues unrelated to trafficking.

When they seek medical services, victims may have been isolated for some time, and may seem disoriented. They may suffer PTSD emotional numbness and detachment, and believe no one can help them. They may have conflicting loyalties, or traumatic bonding with their trafficker. Many may not even understand "trafficking" or identify themselves with the concept of it. Observation of a patient's history, interaction, physical presentation, and mental or emotional state can produce red flags. The following are some things to look for.

- Red Flags: History
  - ◊ A delay in seeking care for an illness/injury
  - ◊ Vague or inconsistent history
  - ◊ Hospital hopping or use of different names
  - ◊ Appears younger than stated age (they may be coached to say they are older than 18)
  - ◊ Child/adolescent traveling with older companion, who is not a parent or guardian
  - ◊ Unable to give address; may have a coached cover story about being a student or tourist
- Red Flags: Interaction/Control indicators
  - ◊ Accompanied by controlling person; doesn't allow patient to answer; interrupts or corrects patient
  - ◊ Subordinate demeanor
  - ◊ Lack of ID, or person with them handles ID
  - ◊ Person with them may pose as spouse, partner, family member or employer
  - ◊ Few personal possessions; cash payment
- Red Flags: Physical
  - ◊ Neglect/delay in care; advanced stage of disease/injury; evidence of prior poor attempt to treat
  - ◊ Exhibits fear, nervousness
  - ◊ Serious industrial injury
  - ◊ Chronic back, hearing, vision, skin, respiratory problems from work conditions or toxic exposures
  - ◊ Persistent or untreated STIs or UTIs
  - ◊ Repeated abortions, miscarriages, or no prenatal care
  - ◊ Evidence of inflicted injury (multiple, old, new)
    - ♦ Bruising, scarring, burns, ligature marks, broken bones
    - ♦ Branding, tattooing of "ownership"
    - ♦ Complications from attempt at induced abortion
    - ♦ Vaginal/anal trauma
- Red Flags: Mental/Emotional
  - ◊ Depression/hopelessness/suicidality
  - ◊ Anxiety/panic attacks
  - ◊ PTSD, disassociation
  - ◊ Disoriented/confused (may be purposely moved from city to city, so don't know where they are)
  - ◊ Addiction
  - ◊ Numbness as a coping mechanism

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What can we do if we suspect a patient is a victim of human trafficking? Always consider the possible danger. Take into consideration whether or not the trafficker present, in the waiting room or outside; if the patient believes he/she or a family member is in danger; if clinic personnel are in any danger; what could happen if the patient doesn't return. Limit involved staff, and make sure they understand that confidentiality is vital, due to possible dangers. If you can talk privately to the patient do so. Only use a hospital interpreter or language line. Carefully and discretely ask questions regarding:

- What type of work they do and what their work hours are;
- How often can they visit or talk to family or friends, or if those visits/conversations are monitored or forbidden;
- Can they come and go as they please; or have they been threatened if they try to leave;
- Where to they eat and sleep, and what are the conditions like;
- Are they paid, or do they owe money to their employer;
- Do they feel pressured to do something they don't want to do;
- Have they been physically hurt;
- Did someone tell them what to say while with healthcare worker.

If they respond with "yes" answers, express your regret that this has happened to them. Let them know that you are there to help them, and that their safety is your first priority. Explain to them that they have rights, and that you can put them in touch with the people who can get them, and their families, to a safe place and help them to rebuild their life.

Be sure to provide the person with a comprehensive health assessment:

- Document range of abuses;
- Head-to-toe physical exam
  - ◊ Include oral health
  - ◊ Signs of nutritional deficiencies;
- Review of Systems including any history of strangulation, head trauma, work exposures, exposures to others with illness;
- Screening labs including STIs and pregnancy;
- Forensic collection as needed.

While human trafficking is currently not a mandated report for medical personnel, it may overlap with mandated reporting for child abuse, domestic violence, sexual abuse or elder abuse. If you believe someone is in danger, call 911 immediately. Otherwise, you should do mandated reports as required by your usual protocol, plus call the National Human Trafficking toll-free hotline whose specialists speak English and Spanish, and can communicate with callers in 200+ additional languages using a 24-hour tele-interpreting service. If there truly is nothing reportable, but you still suspect possible trafficking, let the patient know that there are services available. Ask if he/she would like help. If yes, provide the hotline number, or let them call the hotline right then and there, with you. If no, ask if he/she would like the number for future reference. No matter what, once again, be sure to document the visit completely.

Note:

While researching for this article, I found more information than I ever thought I would on the human trafficking topic. The trafficking problem is much more widespread in the U.S., and even New York State, than I imagined. It was a disturbing topic to undertake, with some very sad statistics and stories out there. I used the term "eye-opening" early in the article, and that is definitely what this was. It is an important topic, and one that everyone in the healthcare field should become more familiar with, as we truly are on the front lines of identifying these victims.

In my email used to distribute this newsletter I included a page with helpful and informative links that I used in my research, as well as some other helpful tools/reference sheets.

Please, take some time to review the documents provided. Keep them easily accessible; there's a good chance you may need them one day.

L to R:
Bev Welshans,
Sue Marasi, Larry DiGiulio,
Kelly Badura, Brian White

On May 10th the UBMD Legal & Compliance Department took part in the 19th Annual Lawyers for Learning Bowling Tournament. Lawyers for Learning volunteers tutor weekly with students at Buffalo Public School 18. In addition, they send dozens of children from P.S. 18 to summer camp at the YMCA's Camp Weona, sponsor many educational field trips, and work on the community garden across the street from the school.

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Report suspect fraud/abuse, potential problems,

or HIPAA concerns.

Ask questions or request guidance | Provide relevant information.

Remain anonymous if you wish | Non-retaliation policy will be adhered to.

(This is a voice mail box monitored during working hours. If there is an immediate threat to person or property, do not leave message; contact direct supervisor immediately!

Compliance Quarterly Quiz

To submit your quiz answers, please click link below:

2018 Second Quarter Quiz

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1. According to CMS Administrator, Seema Verma, as part of CMS' "Patients over Paperwork" initiative, they have proposed an overhaul of the E&M documentation and coding system to dramatically reduce the amount of time doctors have to spend inputting unnecessary information into patient records.
   A. True
   B. False

2. Which of the following statements is true in regards to the proposed E&M changes for 2019?
   A. E&M visits make up 40% of all charges for Medicare physician payment, so changes to documentation requirements for these codes would have wide-reaching impact.
   B. The current system of codes includes 5 levels for office visits, level 1 which is primarily used by nonphysician practitioners, while physicians and other practitioners use levels 2-5, which have time-consuming and consuming documentation requirements.
   C. If enacted, the policy changes would significantly reduce administrative burdens on providers and improve patient care.
   D. All of the statements are true.

3. New York State is not one of the top 4 trafficking destinations.
   A. True
   B. False

4. Which of the following statements about trafficking is false?
   A. Observation of a patient's history, interaction, physical presentation and mental or emotional state can produce red flags.
   B. Trafficked victims will often readily announce that they are victims.
   C. Persons of any age, gender or economic status can become victims.
   D. When they seek medical services, victims may have been isolated for some time, and may seem disoriented. They may not even understand "trafficking" or identify themselves with the concept.

5. If you suspect a patient is a victim of human trafficking:
   A. Always consider the dangers; carefully and discretely ask questions.
   B. Be sure to provide the person with a comprehensive health examination.
   C. If you believe someone is in danger, call 911 immediately. Otherwise call the National Human Trafficking toll-free hotline for specialist assistance.
   D. All of the above.