May 2024

Compliance Quarterly

From the Compliance Office...*The UBMD Compliance Hotline*

Reporting known or suspected non-compliance is the responsibility and duty of all UBMD employees, and can be a valuable source for finding risk areas within UBMD. As the saying goes, "If you see something, say something." The UBMD Compliance Office has an open door policy, as well as a non-retaliation policy. However, some may still be uncomfortable having their identity known. That is why we established the **UBMD Compliance Hotline: 716.888.4752**. The hotline is an untraceable voicemail box which is monitored for messages during regular business hours. While you can choose to remain anonymous, all information relevant for investigation should be provided, including: practice plan/department, date(s) & time(s) of incidents, name(s) of person(s) in question, detailed description of the incident or behavior in question, and any other pertinent information. All calls to the hotline will be investigated.

All UBMD offices should have a Compliance Hotline flier displayed where it is visible to all employees. For a printable PDF copy of the Hotline flier, click here.

Compliance Training Updates

2024 Mandatory Fraud, Waste & Abuse Training

NEW 3rd Party Payer Requirement - Reminder

In October 2023, one of our practices received a notification from Independent Health stating that they require each of their participating provider groups or practices to complete Fraud, Waste & Abuse Training **and submit an electronic attestation to confirm completion of this training by each of their staff members**. They further specify that staff members of practices required to complete this training includes physicians, mid-levels, ancillary providers, registered nurses, licensed practical nurses, administrative and office staff, technicians, coders and others.
FWA training is also a State and Federal requirement for ALL practice administration, providers & staff upon hire and annually thereafter.

New Provider E/M & Documentation Training

Required for all newly hired providers. It also serves as a good refresher for not-so-new providers. This training is now available online by visiting the Education & Training page on the UBMD Compliance website.
(https://ubmd.com/about-ubmd/Compliance/Education-training.html).

Active Shooter Training

In 2022, University Police provided an Active Shooter Training presentation at the Conventus Building, which was recorded so that others could view this important training. All employees, including providers and staff, are **strongly encouraged** to view the video to help ensure your safety, and the safety of those around you. The video helps prepare you both mentally and physically for an active shooter situation, and advises what you should and should not do before and after law enforcement arrives on the scene. Click on the following link, and click on the Active Shooter Training tab to view the video.
(https://www.ubmd.com/about-ubmd/Compliance/Education-training.html)

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HELP WANTED!!

We want you to be involved! Help us help you...if you have a question or topic you would like to see covered (general, specific or practice-focused) in a future edition of the *Compliance Quarterly,* please contact Sue Marasi at: smmarasi@buffalo.edu

HIPAA: What is De-Identification in Healthcare?

Sue Marasi, CHC, CPCA, Compliance Administrator

De-identification is the process to remove personally identifiable information and protected health information from patient data. This allows HIPAA covered entities to share health data without violating HIPAA because the Privacy Rule allows use or disclosure of information for research purposes without a signed authorization or waiver from patients. De-identified data is often shared for things such as medical research, policy assessments, testing software when a wider scope is necessary, and other assessments and studies. It prevents participants from being directly or indirectly identified. There are two methods that can be used for de-identification, Safe Harbor Method and the Expert Determination Method.

Safe Harbor Method: The removal of the following 18 types of identifiers of the individual or of relatives, employers or household members of the patient.

A. Names;
B. All geographic subdivisions small than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of Census:
    1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
    2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
C. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
D. Telephone numbers;
E. Fax Numbers;
F. Email addresses;
G. Social security numbers;
H. Medical record numbers;
I. Health plan beneficiary numbers;
J. Account numbers;
K. Certificate/license numbers;
L. Vehicle identifiers and serial numbers, including license plate numbers;
M. Device identifiers and serial numbers;
N. Web Universal Resource Locators (URLs);
O. Internet Protocol (IP) address numbers;
P. Biometric identifiers, including finger and voice prints;
Q. Full face photographic images and any comparable images;
R. Any other unique identifying number, characteristic, or code.

Expert Determination Method: Expert determination by applying statistical or scientific principals. Covered entity acquires a qualified expert to determine that the risk is very small that the information could be used alone or in combination with other reasonably obtained information by an anticipated recipient to identify the subject individual. According to Health and Human Services, the expert must have appropriate knowledge of and experience with generally acceptable statistical and scientific principles and methods for determining that information is not individually identifiable. The methods and analysis used to make the determination must be fully documented.

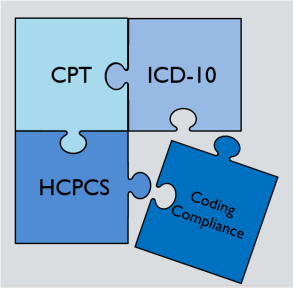
<u>Commonly Asked Questions Regarding De-identification</u>

Q: Can dates associated with tests for a patient be reported in accordance with the Safe Harbor?
A: No. Dates associated with tests, from a lab report for example, are directly related to a specific individual and the health care provided to them. Therefore, the dates are protected health information.

Q: Does a patient's nickname have to be removed from a data set?
A: Any nicknames and other names a patient may be known by must be removed.

Q: Is there an expiration date for de-identified data?
A: The Privacy Rule does not specify an expiration date for de-identified health data.

Sources: hhs.gov and hippajournal.com



The Coding Corner

HCPC Add-on Code to E/M Codes - Visit Complexity Code G2211

Sandy Setlock, CPC, CRC, CEMA, CHCO, Director of Audit & Education

As of January 1, 2024, CMS has implemented a separate add-on payment code listed **as G2211**. This add-on code is to be billed with an Evaluation and Management code. The G2211 inherently was developed for Primary Care Physicians and the focal point of utilization of this code. However, it may be utilized across specialty lines. CMS does not restrict the use of CPT G2211 based on medical specialty.

The definition of the G2211 Add-On code is as follows from the AMA/CPT:

CPT/AMA description for add on code G2211 - ***Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).***

The G2211 will better recognize the resource costs associated with evaluation and management visits for primary care & specialties regarding longitudinal patient care. Generally, it will be applicable for outpatient and office visits as an additional payment, recognizing the inherent costs involved when clinicians are the continuing focal point for all needed services, or are part of ongoing care related to a patient's single, serious condition or a complex condition.

Before billing this code, keep in mind the intent of the code: From a CMS educational transmittal.

A clinician (e.g., primary care, other specialties), as the continuing focal point for all needed health care services for a patient, often bears the cognitive load, responsibility, and an accountability for building the most effective, trusting relationship possible amidst evaluating and managing other health care problems during a visit. Building an effective longitudinal relationship, in and of itself, is a key aspect of providing reasonable and necessary medical care and will make the patient more likely to comply with treatment recommendations after the visit and during future visits.

It is important to remember that this is a new Medicare approved code and not all private payors will reimburse if added to your claims. Please check with your payers as their updated payment policy for 2024 might not reimburse this code for any of their plans. Locally, Highmark (BC/BS) has decided not to reimburse for this code across plan lines.

Even though this is a finalized code, CMS is still working through the documentation guidelines. There are "grey" areas and a lack of detailed guidance areas, leaving room for further guidance and updates from CMS to be issued over the next weeks or months to come. One such example is if two different providers from different specialties try to bill this code on the same date of service, will both of these claims process, or will one of these claims be denied? We are waiting for further guidance from CMS on this area.

Key Factors to Billing Code G2211

When deciding to bill for this code it is important to remember these key points:

1. *Providers who do not intend to have an ongoing longitudinal relationship with the patient (e.g., urgent care, consultants, second opinions, etc.)* **should not bill G2211**.
2. G2211 can only be billed in conjunction with an office or other outpatient evaluation and management (E/M) service.
3. A provider **cannot** bill G2211 when the E/M service is reported with modifier 25 for a **procedure rendered** by the same provider.
4. The add-on code cannot be billed with an office or outpatient evaluation and management [E/M] visit that is itself focused on a procedure or other service instead of being focused on longitudinal care for all needed healthcare services, or a single, serious or complex condition.
5. Do not bill G2211 when chronic/complex conditions are documented **but not considered or addressed in the E/M of the patient**.
6. Add-on code G2211 may be billed with telehealth services. **
7. Automated billing should not be used for this service with all office or other outpatient E/M codes without proper evaluation.
8. Do not Lose sight of the service code G2211 intent, which is to **promote a longitudinal relationship between the provider and patient to improve better care management and positive health outcomes.**

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9. **Longitudinal Care Plan Management** is a Plan that is consolidated, active and thorough, that includes the current treatment, goals, and plans regarding serious and/or complicated conditions. Management of that plan is caring for the patient episodically, and/or through direct care of a single serious/complex problem with updates to the care plan. This **does not mean** a copy and paste template, or carry forward template or macro. **THIS MUST BE SPECIFIC AND UNIQUE TO THE PATIENTS VISIT FOR THE CURRENT IN-OFFICE VISIT (DATE OF SERVICE)**

Examples of when NOT to use G2211

CMS also said in the final rule that visits reported with modifier 25 (*Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*) cannot be billed with G2211. CMS gave some examples in the final rule and clarification where +G2211 should not be separately reported as follows (edited to be specific to gastroenterology as a specialty example).

"When the care furnished during the office/outpatient E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature, such as but not limited to:

- for treatment of a simple virus;
- *initial onset gastroesophageal reflux disease [GERD];*
- **and where comorbidities are either not present or not addressed and/or when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time.**"

An Example of Primary Care Physician:

A patient sees you, their primary care practitioner, for sinus congestion. You may suggest conservative treatment or antibiotics for a sinus infection. You decide on the course of action and the best way to communicate the recommendations to the patient in the visit. How the recommendations are communicated is important in that it not only affects the patient's health outcomes for this visit, but it also can help build an effective and trusting longitudinal relationship between you and the patient. This is key so you can continue to help them meet their primary health care needs.

The complexity that code G2211 captures isn't in the clinical condition – the sinus congestion. The complexity is in the cognitive load of the continued responsibility of being the focal point for all needed services for this patient.

There's an important cognitive effort of using the longitudinal doctor-patient relationship itself in the diagnosis and treatment plan. These factors, even for a simple condition like sinus congestion, make the entire interaction inherently complex. In this example, you may bill G2211.

Documentation Requirements Noted by CMS:

You must document the reason for billing the E/M visit. The visits themselves would need to be medically reasonable and necessary for the practitioner to report G2211. In addition, the documentation would need to illustrate the medical necessity of the outpatient E/M visit. Currently CMS does not require additional documentation. The medical reviewers may use the medical record documentation to confirm the medical necessity of the visit and accuracy of the documentation of the time you spent. These items could serve as supporting documentation for billing code G2211:

- Information included in the medical record or in the claim's history for a patient/practitioner combination, such as diagnoses;
- The practitioner's assessment and plan for the visit;
- Other service codes billed.

As the course of the guidelines develop for G2211, please be aware of alerts or emails from your departments as well as the Compliance Department.

Helpful Resources

- Click here for a PDF document that summarizes the guidance on G2211 that was published by Centers for Medicare & Medicaid Services as of 2/19/2024.

- The following is a link to National Government Services (NGS) webpage regarding HCPCS Code G2211: https://www.ngsmedicare.com/web/ngs/evaluation-and-management?selectedArticleId=10595267&lob=96664&state=97133&rgion=93623

General Compliance: HHS-OIG and NYS OMIG Updates

Sue Marasi, CHC, CPCA, Compliance Administrator

Late last year, we in the Compliance Office attended the 25th Annual Health Care Compliance Conference presented by the University of Rochester Medical Center. Each year a knowledgeable group of compliance professionals give informative presentations on various significant compliance topics.

One of the most popular presentations is an annual one by the Department of Justice (DOJ), Western New York District. They discuss the hot topics that they are presently investigating and areas of concern that they are seeing, and give tips on areas we should focus on based on the work they are doing.

Assistant U.S. Attorney David Coriell first spoke about the Affirmative Civil Enforcement Unit (ACE Unit), which focuses on going after Fraud, Waste and Abuse in healthcare, and recovering money for taxpayers. He explained that half of their cases come from whistleblowers, and others from data analytics, red flags and law enforcement. He went on to mention some current areas of concern and hot topics; areas we need to make sure we are handling correctly at all times:

- Anti-kickback Statute and Stark Law
- Durable Medical Equipment
- Genetic Testing
- Telehealth
- Improper Billing
- Pharmacy Billing
- Medicare Advantage
- Self-Disclosures

Special Investigator Peggy McFarland also spoke, giving her always-popular "Peggy's Plugs," which are the top ten billing and coding areas that the DOJ is seeing problems with on a regular basis and are, therefore, monitoring and focusing on:

1. Bundled codes.
2. Any inpatient stay that begins and ends on same day (one day stay).
3. E&M Codes 81403-81408 & 81479 (Molecular Pathology and Genetic Testing): MUST be Medically Necessary.
4. E&M Codes 99281-99285: Hospitals are billing all the time, and that's a red flag. These emergency department codes require the level of Medical Decision Making to be met and documented for the level of service requested.
5. ICD-10 Code DRG 177: Respiratory Infections and Inflammations with Major Complication or Comorbidity.
6. ICD-10 Code DRG 871: Septicemia or Severe Sepsis.
7. Modifiers:
   - -22: Increase must include a LOT of documentation.
   - -24: Unrelated E&M services during post-op by some providers.
   - -25: Most abused modifier.
   - -59: Procedure and services other than E&M; documentation is a MUST.
   - -91: Have been seeing used incorrectly over and over.
     - ◊ Used when it is necessary to repeat the same lab test on the same day to obtain multiple test results in order t manage treatment of the patient.
     - ◊ Should not be used when lab tests are rerun as a result of equipment or specimen error.
8. Exclusion Lists: Checking them regularly should be a PRIORITY!!
9. DME Equipment: Fraud is out of control in the Western New York district and all over.
10. Data Driven Cases: Look for high Diagnoses Related Groups that stand out. Why are they billed so high?

Errors in these areas can raise a red flag, so it is important be sure you are coding and billing them properly.

They wrapped up their presentation with the following advice:

- It is important to understand regulatory regimes that you are under (Federal, State, local, organizational).
- Make the effort to make sure it is right; seek/consult guidance.
- Address problems up front.
- Self disclose. ***(Always contact the UBMD Compliance Office before self disclosure.)***
- Be forthcoming to DOJ requests, be cooperative, be truthful and act in good faith. ***(Always contact the UBMD Compliance Office if you are contacted by the DOJ.)***

"The time is always right to do what is right."

~ Martin Luther King, Jr.

Office of Inspector General (OIG) By the Numbers

Sue Marasi, CHC, CPCA, Compliance Administrator

On December 1, 2023, the OIG released its Fall 2023 Semiannual Report to Congress in which they reported their activities during the six month period of 4/1/23-9/30/23. It also included information regarding activity for Fiscal Year 2023 (10/1/22-9/30/23). The report describes the OIG's work identifying significant risks, problems, abuses, remedies and investigative outcomes relating to the administration of HHS programs and operations. To the left, is a summary of some of their findings for Fiscal Year 2023.

Audit Reports Issued	127
Evaluation Reports Issued	42
Expected Audit Recoveries	$283.5 Million
Questioned Costs	$1.5 Billion
Potential Savings	$47.2 Million
New Audit & Evaluation Recommendations	464
Expected Investigative Recoveries	$3.16 Billion
Criminal Actions	707
Civil Actions	746
Exclusions	2,112

In addition, the report showed the following activity from the HHS hotline for Fiscal Year 2023, including the "Submit a Complaint" link on the HHS website.

Hotline calls (including callers seeking information)	84,536
Total tips evaluated	36,244
Tips referred for action*	21,740
Closed; no basis provided for further action	1,950
Closed; no HHS violation	537
Closed; other administrative action	12,017
***Sources of Tips Referred for Action:**	
Phone	8,117
OIG website	11,645
Letters or faxes	835
Other	1,143

During the semi-annual reporting period (4/1/23-9/30/23), The HHS Hotline reported expected recoveries of $117,939,623 as a direct result of cases originating from hotline complaints.

UBMD Compliance Office Website:
https://ubmd.com/about-ubmd/Compliance.html

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COMPLIANCE HOTLINE

UBMD COMPLIANCE HOTLINE: 716.888.4752

CONFIDENTIAL!

Report known or suspected fraud/abuse, HIPAA concerns, or other potential problems.

Ask questions or request guidance | Provide relevant information

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

CLICK HERE FOR PRINTABLE FLIER: Hotline Flier

(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:

2024 May Compliance Newsletter Quiz

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1. Which method of de-identification involves removing 18 types of identifiers of the individual or of relatives, employers or household members of the patient?

   A. Expert Determination Method
   B. Historical Method
   C. Safe Harbor Method
   D. None of the above

2. Although originally developed for Primary Care physicians, CMS does not restrict the use of CPT G2211 based on medical specialty.

   A. True
   B. False

3. Which of the following is true regarding billing code G2211?

   A. Providers who do not intend to have an ongoing longitudinal relationship with the patient, such as with urgent care, consultants, and second opinions, should not bill G2211.
   B. A provider cannot bill G2211 when the E/M service is reported with modifier 25 for a procedure rendered by the same provider.
   C. Add-on code G2211 may be billed with telehealth services.
   D. All of the above are true.

4. Current areas of concern that the DOJ is monitoring and focusing on include which of the following?

   A. Modifiers 22, 24, 25, 59, 91
   B. Bundled codes
   C. Exclusion lists
   D. All of the above

5. It is important to understand Federal, State, Local and organizational regulations, and to make sure you're making the effort to do things right, to seek guidance when you are unsure, and to address problems up front.

   A. True
   B. False