SAINT LOUIS UNIVERSITY
OFFICE OF UNIVERSITY COMPLIANCE

January 2017 Compliance Newsletter

International Agreements

The Office of Foreign Assets Control (OFAC) under the United States Department of the Treasury enforces sanctions on countries, organizations and individuals that pose national security, economic or other threats to the United States. OFAC can impose comprehensive or non-country specific sanctions. Cuba, Iran, North Korea, and Syria currently have comprehensive sanctions against them; the sanctions restrict all financial transactions, contracts, and general dealings with these countries. Selective, non-country specific sanctions are imposed on individuals and organizations, as described in their title, these individuals and organizations can be in any country and carry sanctions, even a close ally of the United States.

Licenses are available to allow business to be conducted with sanctioned entities. General licenses are issued by OFAC to allow specific transactions (i.e. educational, research) on a continual basis with a sanctioned entity without lifting the sanctions or requiring the application of a specific license for each transaction. Specific case-by-case licenses are available for application to OFAC for all other circumstances; applicants are at the discretion of OFAC's decision.

In order for Saint Louis University to comply with these federal regulations, all international visitors, vendors or contracts need to be reviewed to verify we are not entering into a business agreement with a sanctioned entity. If you are in the process of working on international visitors, contracts or agreements, please contact Michael Reeves, the Export Control Officer to review the potential risk and license requirements if necessary.

Failure to adhere to these federal regulations and engaging in agreements with a sanctioned entity could lead to fines and/or prison time. OFAC has civil penalties of $250,000 and criminal penalties of $1 million and/or 10 years in prison.

Please contact Michael Reeves with any additional questions, comments or concerns.

Email: mreeves8@slu.edu   Phone: 314-977-5880
Website: https://www.slu.edu/general-counsel-home/compliance/export-controls

2017 Billers' Meeting Schedule
All meetings will be from 10:00-11:00am in the LRC Pitlyk Auditorium C

February 14, 2017

March 14, 2017

April 11, 2017

May 9, 2017

June 13, 2017

COMPLIANCE REQUIREMENTS:

Please check your mySLU page, "Compliance Requirements" section to make sure you have completed all required training, such as Fair Warning Training, HIPAA Training, Annual Compliance Update, or New Employee Compliance Training.

Compliance Office
Schwitalla Hall
Room M229
Phone: 314-977-5545
Hotline: 877-525-(5669)

The CODING CORNER

Observation services can cause quite a headache when things don't fall perfectly into place. How would you code the below scenario?

Q: Jane Smith was admitted to observation on January 1st late at night for further work up of upper abdominal pain the patient had been experiencing. Jane was not evaluated by the admitting physician until the next morning (January 2nd). After the physician's initial face-to-face encounter with the patient and review of her diagnostic studies it was determined that she suffered from gall stones. Jane decided with her physician to schedule a cholecystectomy in the near future so she could make arrangements at home. She was discharged later that day (January 2nd). (See end of Newsletter for answer.)

Medical Decision Making, Medical Necessity and the Electronic Medical Record

Most coders and physicians are aware that medical necessity, as well as medical decision-making, is the deciding factor for claims payments/denials. Medicare and private payers each have their own definition of medical necessity but, according to section 1862 (a) (1) (A) of the Social Security Act, neither will cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve functioning of a malformed body member." Therefore, medical necessity is the first consideration when reviewing all services.

When it comes to selecting the appropriate level of care for any encounter, medical necessity trumps everything else, including the documentation of history, physical exam and medical decision-making, as outlined in Medicare's Documentation Guidelines for Evaluation and Management Services. For physicians, this could mean that "bullet-proof" documentation of these key components will not ensure protection if auditors find that the medical necessity is lacking.

The electronic health record (EHR) makes it very easy to pull information into patient visit notes. The dilemma caused by the ease of pulling this information in: "Is this information really necessary for this visit?" Did the physician pull this information into the note because it was needed for medical decision-making, or was it auto populated by the EHR?

Medicare produces a data file that contains E&M code utilization and charges by specialty, by year. This information is available to anyone wanting to see where they sit on the bell curve of the national median average.
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-01-2.html

While coding above, below, or at the national bell curve for your specialty does not mean you are coding accurately or not, knowing how your personal bell curve stacks up offers a clue to the likelihood of being targeted. Frankly, it is as fraudulent to under code as it is to over code.

Misrepresenting a level of service or procedure performed in order to charge more or receive a higher reimbursement rate is considered up-coding. An office visit with an established patient requires documentation of two out of three key components. A provider using the EHR, could easily document detailed history and detailed exam on every patient. Thereby billing level four high level visits (99214) for every established patient.

Some providers purposely under-code to prevent themselves from being under the scrutiny of insurance companies that may deny or audit claims. Insurance companies are looking for codes to match the documentation on the patient's record.

Often, outlined bullet point notes provide much more information than numerous full paragraph written notes, proving quality, not quantity, is needed to prove medical necessity. A personalized note will clearly support the information that was pulled in and reviewed. The quality of the documentation is far more important than the quantity.

While staying under the bell curve will not make you audit- proof, it does decrease the odds that you will be targeted.

Helpful information can be found the following article found the American Academy of Family Physician's
http://www.aafp.org/fpm/2006/0700/ (Peter R. Jensen, 2006)p28.pdf
and
https://www.aapc.com/blog/32444-mdm-vs-medical-necessity-the-debate-continues/ (Suzan Berman (Hauptman), 2015)

A: These admission services cannot be coded until the provider performs a face-to-face-service. If the face-to-face service for the admission occurs on the same date as the discharge, a code from the single-day observation service codes should be selected. Because the physician provided both admission and discharge services on January 2nd, the appropriate code selection would be CPT 99234 – 99236, dependent upon the documentation provided.