SAINT LOUIS UNIVERSITY

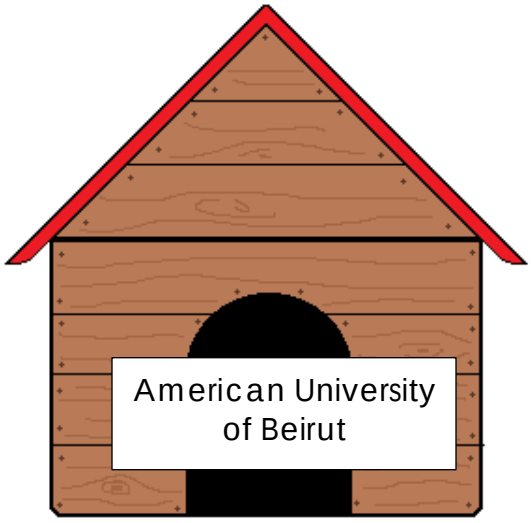
OFFICE OF UNIVERSITY COMPLIANCE

April 2017 Compliance Newsletter

2017 Billers' Meeting Schedule

All meetings will be from 10:00-11:00am

May 9, 2017
June 13, 2017
July 11, 2017
August 8, 2017
September 12, 2017
October 10, 2017
November 14, 2017
December 12, 2017



Export Control Case Settlement

American University of Beirut has reached a $700,000 settlement with the United States Government for violating the False Claims Act by providing material support to three Department of Treasury OFAC sanctioned entities. As a reminder, all foreign visitors, vendors, and collaborators need to be reviewed by the Export Control Officer to ensure SLU's compliance with these federal requirements.

https://www.justice.gov/usao-sdny/pr/acting-manhattan-us-attorney-announces-settlement-american-university-beirut-resolving

Welcome New Employees!

All new employees of SLU are required to complete compliance training within 30 days of their start date. The module can be found on the "Compliance Requirements" section of your mySLU homepage.

The CODING CORNER

Coding Corner

The New Way to Code for Moderate Sedation

A huge change occurred within the moderate (conscious) sedation section of the CPT coding manual effective January 1, 2017. The new codes (CPT 99151-99157) include pre-, intra-, and post-procedural work, however they are time based codes that should be coded according to the intra-service work documented in the medical record. Code selection is also dependent on the patients age and if the provider performing the sedation is the same provider performing the procedure.

		Same Provider	Other provider
Intra-service Time	**Patient Age**	**Codes**	**Codes**
Less than 10 min	Any Age	Not reported separately	Not reported separately
10-22 minutes	<5	99151	99155
10-22 minutes	>5	99152	99156
23-37 minutes	<5	99151 + 99153 x1	99155 + 99157 x1
23-37 minutes	>5	99152 + 99153 x1	99156 + 99157 x1
38-52 minutes	<5	99151 + 99153 x2	99155 + 99157 x2
38-52 minutes	>5	99152 + 99153 x2	99156 + 99157 x2
53-67 minutes	<5	99151 + 99153 x3	99155 + 99157 x3
53-67 minutes	>5	99152 + 99153 x3	99156 + 99157 x3
68-82 minutes	<5	99151 + 99153 x4	99155 + 99157 x4
68-82 minutes	>5	99152 + 99153 x4	99156 + 99157 x4
83 minutes or longer	<5	Add an additional 99153	Add an additional 99153
83 minutes or longer	>5	Add an additional 99153	Add an additional 99153

HIPAA Paid Out of Pocket Restrictions

In 2013, the HIPAA Omnibus Rule added a patient right to protect out of pocket paid services. It specifically provides that patients have a right to obtain restrictions on the disclosure of health information in electronic or any other form to a health plan for payment or healthcare operations with respect to specific items and services for which the individual has paid the covered entity out of pocket in full. Such requests for restrictions must be granted by the practice unless disclosure is required by law.

To comply with this requirement a special procedure was created for handling such requests to honor restrictions of information released from GE/IDX and Epic. A new case must be created and linked to the appointment. The patient is informed they will prepay for the service/treatment and complete the REQUEST for RESTRICTION for Paid Out of Pocket Service form. The completed form is sent to HIM resulting in the setting of the Release Restriction flag in Epic and storage of the document in the patient's record available for viewing in Epic.

Below are GE/IDX required elements for billing paid out of pocket charges.

Case Name: SELF PAY OUT OF POCKET
Case Mnemonic: OOP
Case Number: 999
Case Class: P
Billing Employer/Insurer FSC: 68 – Self Pay Patient Responsibility

Questions regarding handling of Paid Out of Pocket restrictions should be presented to:
Judith Cooper, PMO Training 314-977-6732

REMINDER: *All Foreign Travel must be Approved by Compliance for Export Controls.*

Through Export Controls, the federal government restricts what information, technology and software can be shared with foreign nationals. One of the main areas of concern for SLU is foreign travel by faculty, staff and students. To verify compliance with this complex area of federal regulation, we are asking for international travelers to contact the Export Control Officer prior to any foreign travel.

If you are traveling internationally and either

A) Traveling for SLU Business
B) Taking SLU Equipment

Please contact Michael Reeves, Export Controls Officer at mreeves8@slu.edu or 977-5880 prior to traveling.

Teaching Physician Documentation
Frequently Asked Questions

The role of teaching physicians in academic medical centers goes beyond 'just' treating patients and providing a quality level of care. Teaching physicians are responsible for educating and leading the next generation of physicians into their future prepared to be the best in their specialty, all while staying compliant with the regulations surrounding them. The regulations related to the required medical record documentation of teaching physician services have proved the most confusing regardless of the services provided.

The Centers for Medicare and Medicaid Services (CMS) require physicians that involve residents in the care of their patients must be identified on the claims sent to them for payment. We meet this requirement by appending a GC or GE modifier as appropriate to the applicable services. In order for these services to be payable, we must comply with the documentation guidelines located in Chapter 12 of the CMS Internet Only Manual (IOM). The IOM specifically states that when a physician places the GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements outlined in the manual. The following are the most common 'Frequently Asked Questions' the Compliance Department has received regarding these requirements. Please contact us if any additional questions arise that may not be discussed below.

1. What are an attestation/linking statements?
A teaching physician attestation or 'linking' statement is a statement that documents the minimum requirements for the services provided, which include the service furnished, the participation of the teaching physician in providing the service and whether the teaching physician was physical present.

2. When should a teaching physician document an attestation statement?
The teaching physician should document an appropriate attestation statement, for each of the applicable services performed during an encounter, in which a resident was involved in the care of the patient.

3. What if I (the teaching physician) document my own note?
The following rules apply to each type of service:

Evaluation and Management Services: *In the absence of a note by a resident*, the teaching physician must document as he/she would document an E/M service in a nonteaching setting.

*Where a resident has written notes**, the teaching physician's note may reference the resident's note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient.

*"written notes" are not defined as 'progress notes' and may be titled differently in the notes section of the electronic medical record

Surgical Procedures: The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. If the teaching physician is documenting the operative note, it is best practice to include their presence statement within the documentation

Interpretation of Diagnostic Radiology and Other Diagnostic Tests: If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he/she is indicating that he/she personally performed the interpretation and not official statement is needed. Please note that "Other Diagnostic Tests" are not limited to radiological procedures.

4. Can I use a 'smart' or 'dot' phrase?

When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system. In addition to the teaching physician's macro, either the resident or the teaching physician must provide *customized information* that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date. It is insufficient documentation if both the resident and the teaching physician use macros only.

5. What if I perform a procedure and am unable to bill for the E/M service?
An appropriate attestation statement should be made for each service in which a resident is involved in. That includes E/M services and procedures on the same date of service.

6. Do I have to define the key and critical portions of a surgery?
The IOM does not state that it is a requirement to define the key or critical portions of a surgical procedure. Critical or Key portions are defined as: the part (or parts) of a service that the teaching physician determine is (are) a critical or key portion(s) are not stated to be required as part of the surgical documentation requirements.

7. Can I attest to a medical student's documentation?
Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

The documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note.

It is *never* appropriate to copy and paste another person's documentation and claim it as your own.

8. What should my attestation statement look like?
The following are commonly used attestations for their services, however dependent on the type of service and what was performed, statements may vary.
E&M Services: "I saw and examined the patient and discussed my findings with the resident. My additions and/or exceptions include…"

E&M services subject to the Primary Care Exception: "I have reviewed this patient's history, physical exam, and assessment with the resident at the time of the visit. I agree with their documented plan."

Surgery: "I was present for the entire case" OR "I was present for the key and critical portions of this case"

Diagnostic Tests: "I have personally reviewed and interpreted this test. I agree with the resident's findings" OR "I have personal reviewed and interpreted this test. My findings are _____"
The latter example would be used if you were to disagree with the resident's documentation.

Time Based Services: "I was present for and provided 35 minutes of counseling for this patient's 45 minute visit. We discussed……."

9. Can I attest to a Non-physician Practitioner's note?
No. The attestation or 'linking statement' applies only to residents in the teaching setting. If a service is performed by a physician and a non-physician practitioner within the same practice, see the guidelines for Split/Shared billing.

**We cannot Split/Share bill with a NPP that is a non-SLU*Care* employ