SAINT LOUIS UNIVERSITY

OFFICE OF UNIVERSITY COMPLIANCE

May 2017 Compliance Newsletter

"Personal History of Cancer" When does it start??

"Personal History of Cancer" When does it start?? Is it the day after the cancerous tumor has been removed? Is it the day after the patient has finished their chemotherapy? When 'officially' do you stop using a cancer code?

Per the AMA ICD 10 diagnosis coding guidelines, when coding a primary malignancy that has been previously excised or eradicated from its site and **there is no further treatment directed to the site and there is no evidence of any existing primary malignancy,** a code from the category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

For instance:
A 62 year old woman, new to practice, presents today with ongoing fatigue. She has a personal history of cancerous thyroid, no known metastasis to nodes, which was resolved with total thyroidectomy in 1999. She takes 115 mcg Synthroid daily. Approximately six months ago, she started experiencing debilitating fatigue. She has no changes in diet or appetite, no significant weight gain or loss, no appreciable thirst, no fevers, no tremors, palpitations, no nocturia or polyuria. No appreciable symptoms other than fatigue. Daily naps seem to help.
Patient has never smoked, does not drink alcohol, and has two grown children. Her past history is significant for the thyroid cancer only. She reports no family history of thyroid issues.

Exam reveals well developed, well-nourished pleasant woman in no acute distress, weight 143 lbs, BP 124/68, P 90, R 16, T 99.1, eyes clear, surgical scar at neck, respirations non labored, cardiovascular regular rate and rhythm. No proximal muscle weakness or edema of extremities, no cyanosis or bruising of skin.

I will send her to have TSH, Thyroglobulin panel drawn. She will continue her 115 mcg Synthroid daily. I reviewed with patient that she should take thyroid medication on an empty stomach one hour before food or three hours after food.

I have refilled her Synthroid prescription, given her a Quest lab form to obtain her blood work. My office will contact patient when lab results are available. She will return in two months unless, after reviewing lab results, I change this course of treatment.

Diagnosis: Fatigue, hypothyroidism.

CPT Code: 99203 - Detailed history, Comprehensive exam, Moderate medical decision making.
The ICD 10 diagnosis codes for this note would be:

1. R53.83 - Other Fatigue NOS
2. E89.0 - Post op Hypothyroidism
3. Z85.850 - Personal history of thyroid cancer

This patient is not being treated for cancer. The first diagnosis she came to the provider for was fatigue. The second diagnosis is hypothyroidism, which the provider has refilled a prescription and is running blood work. The provider is not treating this patient for cancer. There is no documented evidence that there is an active malignancy so, the third diagnosis is personal history of thyroid cancer.

2017 Billers' Meeting Schedule

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

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

COMPLIANCE REQUIREMENTS:

Please check your mySLU page, "Compliance Requirements" section to make sure you have completed all required training.

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 as either NEWEMPCUFY2016 or NEWEMPCUFY2017, depending on your start date.

The CODING CORNER

Coding Corner

Question: When a malignant lesion is excised and the resultant skin defect is closed with a z-plasty, what code(s) should be reported?

a.) Z-plasty (14000-14061)
b.) Lesion excision (11600-11646) and the Z-plasty (14000-14061)
c.) Lesion excision (11600-11646)
d.) Complex repair (13100-13160)

ANSWER BELOW

Physician Pleads Guilty to Fraud for "Canned Language"

Recently, Dr. Yev Gray, a podiatrist from Chicago, admitted to defrauding Medicare out of more than 6 million dollars. The Office of Inspector General (OIG) started questioning the services that Dr. Gray's health care company provided to patients in a nursing home in Missouri. According to the plea agreement certain services had been denied by insurance carriers as not necessary, but were still being provided. The doctor created 'canned' language that 'pretty much assured [that] Medicare would pay' for the service as documented. The OIG received complaints that the documentation contained in this canned language was inaccurate as documented in the EHR. Upon review the documentation for various patients was found to be substantially the same.

The Centers for Medicare and Medicaid Services (CMS) and the OIG are narrowing their focus on electronic medical record documentation in their reviews. Having auto-generated and copied and pasted documentation that creates homogeneous notes is clearly a high risk for potentially fraudulent activity. Please see the October 2016 Compliance Newsletter that provides additional information on this topic.

Coding Corner Answer

Answer: a.) Z-plasty (14000-14061)

Rationale: Per CPT guidelines, when a lesion is excised and the resultant defect is closed with adjacent tissue transfer, only the tissue transfer is coded. See definitions preceding code 14000. Examples of adjacent tissue transfers include Z-plasty, W-plasty, V–Y-plasty, rotation flap, advancement flap, and double-pedicle flap. It is inappropriate to assign an excision code along with an adjacent tissue transfer code.

Source: AHIMA 2016 Clinical Coding Workout

A Patient's Right to Amend PHI

The HIPAA Privacy Rule provides patient's with the right to request an amendment of their health information within their medical record if they believe the information is incorrect or incomplete.

While Saint Louis University accepts requests for amendment, it is not required that we agree to the amendment or that we are obligated to make changes to the record under certain scenarios. Reasons a request for amendment may be denied include:

- PHI was not created by the Saint Louis University (SLUCare)
- PHI is not part of the patient's designated record set
- Federal law forbids making the PHI in question available to the patient for inspection
- PHI is accurate and complete

It's important that providers and other treatment staff are aware of the patient's right to request amendment of their record and address the concern in a timely manner. Patients should be informed to contact the Health Information Management (HIM) department or the Privacy Officer to execute a request. Such requests may be more common as MyChart functionality is expanded to include shared notes.

Health Information Management (HIM) personnel are responsible for receiving, processing, and responding to requests for amendments to protected health information. Individual requests for amendments to protected health information must be in writing and directed to HIM.

Policies related patient's right to amend may be reviewed in ***PolicyStat***.

- Right to Amend
- Denial of Request to Amend

Questions regarding patient's right to amend may be directed to one of the following contacts:

Health Information Management 314-977-6021
Privacy Officer 314-977-5545

Time Study Reporting Guidance

All SLU Medical School faculty who provide contracted graduate medical education (GME) activities in delivery of patient care services at SSM facilities are required to submit a certified Faculty Physician Time Study Report each month. The Medicare Cost Report System requires that teaching hospitals be able to demonstrate their GME program compliance through the documentation of direct costs including faculty physician salaries. This is accomplished by collecting a representative sample of how each faculty member spends their time related to teaching activities with residents and fellows through the monthly Time Study Reports. The reports run Sunday through Saturday over a randomly selected week for each month of the year, and should be submitted to the department's business manager with a "live signature" certifying their completeness and accuracy.

Time Study Reports provide a reasonable basis for allocating faculty salaries between teaching and non-teaching activities at three SSM hospitals: SLU-Hospital, Cardinal Glennon, and St. Marys. It is understandable if the assigned sample week is not one's typical week due to attending a conference or some other anomaly, as the atypical week will be combined with data collected over the other 11 months of the year to arrive at a reasonable approximation of one's time. If a faculty member anticipates a vacation over the sample week covered by the Time Study Report, they may opt to collect their time the adjoining week immediately before or after the sample week. This alternative week method is acceptable only for the rare exception as it is administratively difficult to manage.

Time Study Reports will likely not include all of the faculty member's time because one's responsibilities over an entire work week are typically greater than GME teaching and hospital administration. For example, patient care time spent alone or with medical students providing direct and personal care that is to be billed under Medicare Part B would not ever be reported on the Time Study Reports. Therefore, it is unusual for a faculty member to report a full work week, estimated at 60 hours, on their Time Study Report.

Please take note of the following guidelines related to your Time Study Report:

Report as Teaching Activity:
• Time spent teaching, advising, and guiding trainees, including residents or fellows. This will take place within the three SSM locations (SLU-H, Cardinal Glennon, St. Marys), as well as Ambulatory Care settings, Lecture Halls, and other training locations dictated by ACGME • Time with trainees reviewing records and demonstrating patient care through physical and history documentation • On-Call time in which you provided guidance to a resident or fellow by phone or in person • Time spent planning, managing, scheduling and coordinating time with trainees • Time spent preparing documentation for accreditation • Time spent developing curriculum
Report as Hospital Administration Activity:
• Oversight time of units for Medical Direction • Participation time on hospital committees • Time spent supervising and training clinical staff, including nurses and technicians who are not residents • Time spent on Quality Assurance activities
Do Not Report on Time Study Form:
• Time spent on Research • Time spent on Non-Clinical activities • Time personally spent in the direct performance of patient care services • Time spent with a resident who is only observing the direct and personal patient care provided by the Faculty Physician • Time spent on clinical activities at other hospitals and clinical sites, other than SSM SLU-Hospital, Cardinal Glennon, and St. Marys • On-Call time in which no direct oversight was provided • Time spent with only medical students

Medicare Audits require the Time Study Reports as a necessary feature to ensure the continuation of CMS funding for GME programs. Accuracy and completeness are essential. Ask your Business Manager if you have any questions about the Time Study Reports and consider watching a 16-minute Tegrity Video authored by Dr. Julie Gammack, Associate Dean for Graduate Medical Education, in November, 2015 from which this article is largely based. Additional questions should be submitted to SLUCare's Chief Operating Officer, Kathy Merlo, at merlokb@slu.edu, 314-977-5883.