The Compliance Companion

Our Practitioner Newsletter

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Contact Us

Nationwide Children's Hospital
Corporate Compliance Office
255 E. Main Street, 1st Floor
Columbus, OH 43215

PHONE 614.355.0400
FAX 614.355.0404

Office of Research Compliance & Integrity
Wexner & Research Bldg. II
PHONE 614.722.2599

Correcting the Date of Service on Inpatient, ED/UC Services in EPIC

Situation:

Incorrect dates of service auto-populate on provider documentation for Inpatient services, Emergency Department services and Urgent Care services.

Background:

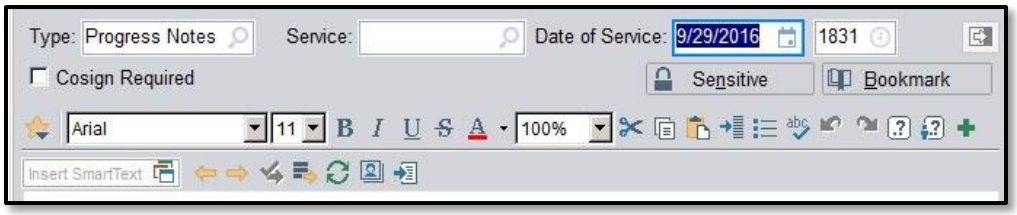
Due to EPIC functionality, the date of service is auto-populated based on the date the provider initiates the note documentation. Providers may be unaware of the need or ability to manually correct the date of service field to reflect the actual date the provider saw the patient. As a result, the auto-populated date may lead to unintentional misrepresentation of the actual patient encounter date in the medical record. The dates of service in the medical record will not match the dates of service that are billed by the provider.

Assessment:

In accordance with CMS guidelines, the medical record documentation and service date on claims must represent the actual provider face-to-face encounter date. The medical record documentation and billed service dates should match.

Recommendation:

If a provider is not documenting on the actual face-to-face date of service, they will need to manually override the default date in Epic and enter the actual visit date before selecting the level of service.



Dr. Steve Roach, *Corporate Compliance Medical Director & Practitioner Compliance Committee Chair*

DOJ Announces Substantial Increase in Rates for False Claims Act Penalties

Recently the Department of Justice (DOJ) increased the per-claim penalty for violating the *False Claims Act*. The DOJ raised the minimum per-claim penalty from $5,500 to $10,781 and the maximum per-claim penalty from $11,000 to $21,563. This new ruling went into effect for violations that occurred after November 2, 2015 and associated penalties assessed after August 1, 2016.

A "False Claim" is a bill or invoice (e.g. claim) sent to the federal or state government for reimbursement or payment that is inaccurate or misrepresents actual events. A person or entity violates the *False Claims Act* by knowingly submitting a false claim for reimbursement. Some actions which could result in the submission of a false claim include, but are not limited to:

- Billing for services or goods not provided;
- Changing the diagnosis to receive payment;
- Billing for a higher service than actually furnished (up-coding);
- Billing for services not medically necessary;
- Duplicate billing;
- Failing to refund known overpayments to the federal/state government;
- Falsifying statements in the medical record to bill a service (including teaching physician attestations);
- Falsifying information on a grant application to the federal government;
- Falsifying research data on a federally funded grant;
- Falsifying time/effort reporting related to a federally funded grant/contract.

Please review the **NCH Fraud, Abuse and Waste policy** for additional information about the False Claims Act.

John Grosh, *Corporate Compliance Coordinator*

Be A Zero Hero When Receiving Suspicious Emails

"Phishing" is a way for malicious third parties to attempt to gain access to a secure network. Most phishing is done by sending an email that tries to trick you into providing information, like your login credentials.

Most people are used to the old types of phishing emails where there are numerous spelling and grammar mistakes with a clearly made up scenario. However, hackers have gotten smarter. A practice called "spear phishing" is becoming much more popular. This is when a hacker includes information in the email that is specific to you as an individual to give a false sense of legitimacy to the message. They may include your job title or mention the name of a coworker.

If you receive an email requesting sensitive information or one that contains a link, have a questioning attitude and use your *Zero Hero* tool, **QVV**:

Qualify the source – Do you trust this source?

Validate the content – Does this request make sense to you? Were you expecting an email about this?

Verify your action with an expert – If you are not sure of an email's legitimacy, call the NCH Support Center at (614) 355-3750 or forward it to *NCHSupportCenter@nationwidechildrens.org*.

Kristin Maple, *IS Systems Security Analyst*

Hospital Discharge Day Management Services

A **Hospital Discharge Day Management Service** is a face-to-face evaluation and management (E/M) service between the attending physician and the patient.

There are two time-based CPT codes for inpatient hospital discharge day management services.

99238 Hospital discharge day management, 30 minutes or less.

99239 Hospital discharge day management, more than 30 minutes.

Physicians should report only one discharge CPT code per hospitalization**. The date of service is based on the provider's actual face-to-face visit with the patient even if the patient is discharged on a different calendar date.**

These CPT codes are utilized to report the total duration of time spent by the physician for final hospital discharge of the patient. These codes include, as appropriate:

- Final examination of the patient;
- Discussion of the hospital stay, even if the time spent by the physician on that date is not continuous;
- Instructions for continuing care to all relevant caregivers; and
- Preparation of discharge records, prescriptions, and referral forms.

There are no requirements to document each of the above components. Physician documentation must refer to the discharge status, the attending physician's face-to-face encounter with the patient, as well as other clinically relevant information. Even though there is no requirement to perform a discharge exam, documentation of a discharge exam will help support the requirement that a face-to-face encounter with the patient occurred.

Don't be misled into believing that the presence of a discharge summary alone satisfies documentation requirements for inpatient discharge management services. Discharge summaries do not always reflect the attending physician's required face-to-face encounter with the patient or the amount of time spent performing discharge management services. **Physicians need to document a separate note in the summary, indicating when the face-to-face encounter occurred and other appropriate documentation to support the billed CPT code, as described previously.**

The provider needs to document the total duration of time spent by the provider performing final discharge services. If time is not documented, the service will be billed under the lower time-based CPT code, 99238. Discharge services performed by residents, students, or ancillary staff (i.e., registered nurses) do not count toward the discharge service time.

Observation Care

Patients discharged from observation care on a date other than the observation admit date are billed under CPT code **99217**.

Observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service are reported utilizing CPT codes **99234-99236** based on the level of history, exam, and medical decision making provided and documented.

Crystal Stevens, *Patient Accounts Director, Professional Billing*

What You Need to Know about Flu Season and Modifier 25

We are approaching flu season: Seasonal flu activity may begin as early as October and continue through late May. The clinic schedules will be filled with patients seeking their annual flu vaccine.

Providers need to use Modifier 25 with evaluation and management (E&M) service codes when a provider visit is performed in conjunction with immunization administration. Appending modifier 25 to the E&M indicates that the E&M performed was a significant, separately identifiable service above and beyond the medical service (vaccine) provided. When the patient's reason for visit is solely to receive the immunization, an E&M is not separately reportable.

For example: administration of a seasonal flu vaccine to a 6 year old during a follow up office visit for asthma.

The provider would code 99213-25 (level 3) with appropriate asthma diagnosis code. The provider would also use 90685 for influenza virus vaccine, G0008 for administration code, and Z23 for diagnosis code.

Lisa Olverson CPC, *Outpatient Professional Coding Supervisor, Health Information Management*

Policy Sets Forth Guidelines on Timely Outpatient Note Documentation

NCH has a policy to address timely documentation in the outpatient locations. This policy applies to all outpatient locations, including the behavioral health locations, urgent care and emergency department. The policy sets forth the following expectations:

- Outpatient encounter notes should be documented as soon as possible, no later than four business days after the rendered service.
- Procedure notes should be documented immediately upon completion of the procedure.
- A practitioner should not bill a service until the note documentation is complete, signed and the outpatient encounter is closed.
- While supervising residents or fellows, attending physicians are expected to document in accordance with the teaching physician rules.

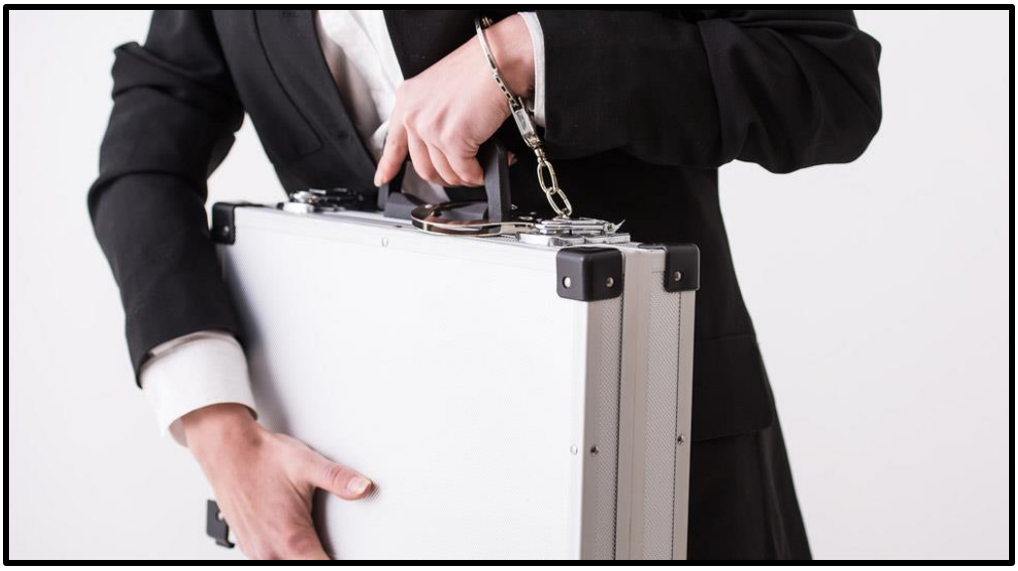
Please review Administrative Policy XII-18 (Outpatient clinic note documentation and encounter closure policy) for additional information.

Kathleen Dunn, *VP and Compliance Officer*

The Transportation of Protected Health Information

Per HIPAA law, Protected Health Information (PHI) must remain confidential and secure at all times. This poses an interesting dilemma for a hospital like NCH that has many off-site facilities, a large provider base, and several community-based programs.

Any employee, including medical staff, who needs to take PHI off of hospital property, must first complete an Application for Transport of PHI. This application must be submitted to the Privacy Office and approved *before* transporting. Please be aware that PHI is not simply computer printouts from Epic or other systems you may use; even your personal notes taken in a meeting or during rounds can be considered PHI if patient identifiers are included.



Transporting PHI is very risky! This hospital's largest breach to date stemmed from an incident where PHI was stolen from a provider's car while the provider was having dinner at a local restaurant. As a result, the provider was sanctioned and NCH was required by law to individually notify over 250 patients. One of the highest profile breaches in the country is due to a physician in Boston losing paper-based PHI on the subway.

The associated hospital from that incident was fined over $1 million dollars by the Office for Civil Rights. If you're required to transport PHI to fulfill your job duties, please take these incidents to heart and remember to always carry the PHI on your person at all times, no matter what. Doing so will protect yourself, your patients, and Nationwide Children's Hospital. **PHI should never be left unattended, especially in plain sight in your vehicle.** While you may not think your work bag will be stolen from your vehicle, it is a prime target for thieves who only need seconds to smash and grab.

Are you still thinking about transporting PHI, despite the risks? Before taking anything off campus, please make sure to think of possible alternatives. For example, any paper-based information can easily be made electronic by simply scanning it at your department's scanner/copier. Once electronic, that information can be transferred to an encrypted thumb drive and transported safely (with an approved transport application), thus negating nearly all the risks of transporting the paper-based copy. An added benefit in this example: NCH offers free encrypted thumb drives through the IS Depot in Ross Hall! For more alternatives, please read Administrative Policy XI-29 which can be found on Anchor.

Please make sure to first think of the alternatives and the risks before transporting any PHI. If you need to transport, make sure to fill out the Application for Transport of PHI and submit it to the Privacy Office for approval. Be a *Zero Hero* and *HIPAA Champion* by never leaving PHI unattended in your vehicle! If you have any questions or concerns regarding transporting PHI, please visit our HIPAA SharePoint site or email us at PrivacyOffice@nationwidechildrens.org.

Rob Hutchison, *Privacy Coordinator, Health Information Management*

HIPAA Highlight: Increase in Employee Non-Compliance

Did you know it is against hospital policy to send Protected Health Information (PHI) to your personal email account? This practice puts the patient's PHI at risk due to it leaving and then sitting on an unsecure network. Also, did you know it is against hospital policy for staff and physicians to access their own, their child's, or a family member's chart?

Due to an increase in these incidents, the Privacy Office will begin to notify both the employee *and* their manager when these events occur. Managers, please use these notifications as a training opportunity! Be a *Zero Hero* and *HIPAA Champion* by educating your staff to stay compliant! If you have any questions or concerns, please email us at the PrivacyOffice@nationwidechildrens.org or visit our HIPAA SharePoint site.

Bridgette Sabine, *Privacy Coordinator, Health Information Management*

New Communication Process Coming from Outpatient Professional Coding

The Outpatient Professional Coding department is preparing to launch a new Provider/Coder Query process. We are now able to provide two-way feedback to providers regarding your outpatient coding. Stay tuned for more information regarding this new process that will be in effect in early October 2016. For questions, please contact Lisa Olverson at (614) 355-0405.

Lisa Olverson CPC, *Outpatient Professional Coding Supervisor, Health Information Management*

Here We Grow Again: Compliance Welcomes New Coding & Compliance Auditor

Bebe Phommachanh has been with Nationwide Children's Hospital since fall of 2015. She started as a Cardiology Coding Specialist for PAA and recently decided to further her career and expand her knowledge in Coding and Compliance. She has a bachelor of science from The Ohio State University in Health Information Management and Systems and two certifications in professional coding and cardiology coding from AAPC.

Since graduating college, she has worked at the Zangmeister Center in Research Oncology and spent six years at Mount Carmel Clinical Cardiovascular Specialist. She is looking forward to learning more in her new role as a Coding and Compliance Auditor and meeting new people in the field. She joins our team on October 31, 2016.

Celebrate Compliance, Privacy and Security during the Month of November 2016

Join the Corporate Compliance Office, the Office of Research Compliance & Integrity (ORCI), the Privacy Office and the Information Security & Risk Department at the **Employee Health & Benefits Fair** on Tuesday, November 1 from 10:00-2:00 in Stecker Auditorium.

Visit the ORCI table at the **Research Retreat** on Thursday, November 17 from 8:00-5:00 at the Ohio Union at The Ohio State University. To learn more about the retreat and to register by the November 1 deadline, visit the Research Retreat online portal.

Earn "Compliance Credit" by Taking this Quiz

Physicians can earn 0.50 Compliance Credits by taking this quiz. Simply answer the ten questions below and submit your answers to the Corporate Compliance Office via e-mail by forwarding your answers to the newsletter editor: **John.Grosh@NationwideChildrens.org** or **fax your answers to 614-355-0404** no later than Tuesday, November 15, 2016.

1. When selecting a discharge day management code, the date of service is based on the provider's actual face-to-face visit with the patients, even if the patient is discharged on a difference calendar day.
   a. True
   b. False

2. A provider has 30 days from the date of service to document the outpatient encounter notes.
   a. True
   b. False

3. When a provider enters documentation for an inpatient visit the day after the face-to-face encounter, the provider must manually change the default date in the date of service field.
   a. True
   b. False

4. If you receive a suspicious email requesting sensitive info, you should have a questioning attitude and employ which Zero Hero tool?
   a. QAA (Quantify, Ask and Approve)
   b. RACE (Rescue, Alarm, Contain, Evacuate)
   c. QVV (Qualify, Validate and Verify)
   d. None of the above.

5. The DOJ has recently doubled the per-claim penalty for violating the False Claims Act.
   a. True
   b. False

6. PHI removed from hospital property can be left unattended as long as an "Application for Transport of PHI" has been approved by the Privacy Office.
   a. True
   b. False

7. It is against hospital policy for anyone to send PHI to their personal email address.
   a. True
   b. False

8. Changing the diagnosis in order to receive payment could result in a violation of the False Claims Act, with penalties ranging from $11,000-$21,563.
   a. True
   b. False

9. Documentation of the total duration of time spent by the provider performing final discharge services does not include time spent by residents, students or ancillary staff.
   a. True
   b. False

10. Members of the Medical Staff who need to take Protected Health Information off hospital property are exempt from completing an "Application for Transport of PHI."
   a. True
   b. False

Physician Name (Print): _____.

Physician Signature: _____. Date: _____.

CONCERNS?

Call the Hotline at 1-877-267-1935

Report on the Web
https://nationwidechildrens.alertline.com

The purpose of the Compliance Office is embodied in our new Vision Statement: To ensure and support an ethical culture of compliance through prevention, detection and remediation.

The means by which we plan to achieve our goals is expressed in our new Mission Statement: To promote integrity and compliance through open communication, education and oversight across the organization in order to deliver the highest quality health care.