Medical Compliance Services
Office of Billing Compliance
Coding, Billing &
Documentation
2016

Critical Care Services
Why Are We Here?

• To **EDUCATE** and **PROTECT** our providers and organization

• To provide you with every tool you need to maximize compliance and get paid what you deserve

• To update you on the latest CMS/OIG activities
Question to CMS: “...confused concerning the timeliness of my documentation in connection with the provider signature and submitting the claim to Medicare, and the timely filing rule. Can you provide more information?

• Answer: There are several provisions that may affect "timeliness" when talking about documentation.
  • A provider may not submit a claim to Medicare until the documentation is completed.
    • Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done.
  • The second is that practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
    • CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself.
Critical Care

Critical Care Services may only be billed with 99291/99292 for urgent medically necessary services that meet these definitions and criteria:

1. **Critical condition**: A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition which requires the highest level of physician/NPP preparedness to intervene urgently.

   And

2. **Personal direct critical care treatment**: Involves high complexity medical decision making to assess, manipulate, and support vital function(s) to treat single or multiple vital organ system failure and/or prevent further life threatening deterioration of patient’s condition.

   And

3. **Direct personal attention at the bedside or on the floor/unit where patient is housed at least 30 minutes or more**

   Documentation must support these 3 requirements.

   And: If resident has documented, teaching attestation must PERSONALLY support these 3 requirements.
CMS - Medicare Focused Audits 2014 on Critical Care and Nationwide Letters

4/1/14-6/30/14: Southern California error rate: 63% for 99291 and 69% for 99292

CMS provided education and expects to see improvement. **Core Issues:**

- **Failure to submit documentation** – Documentation was not submitted to support the claims submitted to Medicare by the time frame indicated in the Automated Development Letter.

- **Time** – Total amount of TP time must be documented in patient's medical record for each ‘DOS’.

- **Medical necessity of the service** – Documentation failed to support the medical necessity of the services rendered per the CMS Internet Only Manual (IOM), Publication 100-04, Chapter 12, Section 30.6.12 and the 1995 or 1997 E/M Guides.

- **Level of service** – Documentation did not support the level of service of CC. Descriptive information with a clearly defined plan to assist in determining the amount and complexity of the patient management is missing. Documentation does not include orders or plan to support any changes made in management strategies and interventions. Example: "Continue current treatments and plan" with no explanation of the plan is insufficient documentation for an accurate determination of level of care.

- **Signatures** – CMS rules pertaining to signatures apply to all providers of Medicare services. Lack of a valid signature is most notable when the medical record is in the electronic format.

- **Split/Shared Services** – Documentation reflected that critical care was performed as a split or shared service between a physician and a qualified non-physician practitioner such as a Physician Assistant or a Nurse Practitioner.
Critical Care Conditions

Examples of vital organ system failure:
- Central nervous system failure, circulatory failure, shock-like conditions,
- Renal, hepatic, metabolic, or respiratory failure,
- Unexpected postoperative complications or overwhelming infection, or
- Other vital system functions to treat single or multiple vital organ system failure or to prevent further deterioration.

Examples of diagnoses that might support necessity for critical care services:
- Acute myocardial infarction,
- Seizures, acute CVA,
- Multiple injuries, significant trauma,
- Acute CHF,
- Septicemia, post operative hemorrhage,
- Postoperative respiratory failure.

Even if condition is critical, 99291 may only be billed if:
- Treatment also meets requirements and
- Time is 30 minutes or greater
Examples of Conditions That May Warrant Critical Care Services

- 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.

- 70 year old admitted for right lower lobe pneumococcal pneumonia with history of COPD becomes hypoxic and hypotensive 2 days after admission.

- 68 year old admitted for acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.
Examples That Generally Do Not Meet ‘Condition’ Criteria for Critical Care

• Daily management of a patient on chronic ventilator therapy.

• Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose that is stabilizing).

• Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

• Patients admitted to a critical care unit because no other hospital beds were available
Critical Care Treatment Definition/Criteria:

• Requires physician or other qualified healthcare professional direct delivery and personal management of medical care for critically ill/injured patient.

• Critical care involves high complexity medical decision making to assess, manipulate, and support vital function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of patient’s condition.

• Although critical care typically requires interpretation of multiple physiologic databases and/or application of advanced technology(s) to manage patient, critical care may be provided in life threatening situations when these elements are not present.
Delivering critical care in the moment of crisis is not the only requirement for billing critical care. **Treatment and management of a patient’s condition, in the threat of imminent deterioration; while not necessarily emergent, is required to prevent further life threatening deterioration in the patient’s condition.**

- **COMFORT MEASURES, AWAIT FOR FAMILY TO REMOVE LIFE SUPPORT, READY TO WEAN OR TRANSFER TO FLOOR/HOSPICE DO NOT GENERALLY MEET CC TREATMENT FOR BILLING**

Prevention is sometimes difficult to ‘see’ in notes. Critical care comprises decision making, not only interventions. If decision making is involved for an extremely tenable patient, that activity is a billable service. Reviewing the situation, weighing alternatives and making informed decisions about the care is billable even if there are no changes to the treatment and no intervention. **Merely reviewing or itemizing what someone else did previously (noting drip settings, writing that the previous treatment continues, and noting that you concur with it) is not billable as critical care.**
Critical Care Treatment Examples

- Thrombolytics
- Anti-arrhythmics
- Epinephrine, Atropine, Sodium Bicarbonate
- Cardioversion for Atrial Fibrillation or Atrial Flutter
- Defibrillation
- Fluid and/or Blood administration for shock or impending shock
- Narcan
- NTG drip
- Initiation of Mechanical ventilation – CPAP, BiPap, or ETT

An 81 year old male patient admitted to ICU following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and vasopressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
# Neuro Examples

<table>
<thead>
<tr>
<th>Condition</th>
<th>Critical Care Treatment</th>
<th>Non - Critical Care Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVA/stroke</td>
<td>tPA started by billing physician</td>
<td>tPA monitoring that was started by ER physician</td>
</tr>
<tr>
<td></td>
<td>High-risk medication</td>
<td>Postop management with no complications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oral prescriptions</td>
</tr>
<tr>
<td>Subdural hemorrhoma</td>
<td>High-risk medication management</td>
<td>Routine neuro checks</td>
</tr>
<tr>
<td></td>
<td>ICP (intracerebral pressure) monitoring</td>
<td>Postop management with no complications</td>
</tr>
<tr>
<td></td>
<td>Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Oral prescriptions</td>
</tr>
<tr>
<td></td>
<td>Blood transfusion</td>
<td></td>
</tr>
<tr>
<td>Subarachnoid hemorrhage</td>
<td>High-risk medication management</td>
<td>Routine neuro checks</td>
</tr>
<tr>
<td></td>
<td>ICP (intracerebral pressure) monitoring</td>
<td>Postop management with no complications</td>
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<tr>
<td></td>
<td>Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Oral prescriptions</td>
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<td></td>
<td>Blood transfusion</td>
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</tr>
<tr>
<td>AMS</td>
<td>High-risk medication management</td>
<td>Routine neuro checks</td>
</tr>
<tr>
<td></td>
<td>Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Postop management with no complications</td>
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<td>Oral prescriptions</td>
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<tr>
<td>Delirium</td>
<td>High-risk medication management</td>
<td>Routine neuro checks</td>
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<tr>
<td></td>
<td></td>
<td>Postop management with no complications</td>
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<tr>
<td></td>
<td></td>
<td>Oral prescriptions</td>
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<tr>
<td>Loss of consciousness</td>
<td>High-risk medication management</td>
<td>Routine neuro checks</td>
</tr>
<tr>
<td></td>
<td>Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Postop management with no complications</td>
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<tr>
<td></td>
<td></td>
<td>Oral prescriptions</td>
</tr>
<tr>
<td>Ruptured brain aneurysm</td>
<td>High-risk medication management</td>
<td>Routine neuro checks</td>
</tr>
<tr>
<td></td>
<td>ICP (intracerebral pressure) monitoring</td>
<td>Postop management with no complications</td>
</tr>
<tr>
<td></td>
<td>Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Oral prescriptions</td>
</tr>
<tr>
<td></td>
<td>Blood transfusion</td>
<td></td>
</tr>
<tr>
<td>Traumatic brain injury</td>
<td>High-risk medication management</td>
<td>Routine neuro checks</td>
</tr>
<tr>
<td></td>
<td>ICP (intracerebral pressure) monitoring</td>
<td>Postop management with no complications</td>
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<td></td>
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<td>Oral prescriptions</td>
</tr>
</tbody>
</table>
# Cardio Examples

<table>
<thead>
<tr>
<th>Condition</th>
<th>Critical Care Treatment</th>
<th>Non - Critical Care Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute kidney failure</td>
<td>Fluid resuscitation (bolus)</td>
<td>Routine hemodialysis for patient with CKD</td>
</tr>
<tr>
<td>Acute respiratory distress</td>
<td>High-risk medication monitoring, Mechanical ventilation (CPAP, BiPap, ETT), CPR</td>
<td>Postop ventilation that is being weaned</td>
</tr>
<tr>
<td>Acute respiratory failure</td>
<td>High-risk medication monitoring, Mechanical ventilation (CPAP, BiPap, ETT), CPR</td>
<td>Postop ventilation that is being weaned</td>
</tr>
<tr>
<td>AFIB</td>
<td>High-risk medication to regulate heart rate, Cardioversion, Fluid resuscitation (bolus)</td>
<td>Routine Coumadin, PRN medication</td>
</tr>
<tr>
<td>CABG ICU management</td>
<td>N/A, If complication arises, see above list.</td>
<td>Routine vital sign checks for critically ill patient, Postop management with no complications, Oral prescriptions</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>High-risk medication monitoring, Pressors, Mechanical ventilation (CPAP, BiPap, ETT), CPR</td>
<td>Routine monitoring after a patient has crashed (i.e. day before) and is now stable, Oral prescriptions</td>
</tr>
<tr>
<td>Cardiogenic shock without mention of trauma</td>
<td>High-risk medication monitoring, Pressors, Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Routine vital sign checks for critically ill patient, Oral prescriptions</td>
</tr>
<tr>
<td>Circulatory failure</td>
<td>High-risk medication monitoring</td>
<td>Routine vital sign checks for critically ill patient</td>
</tr>
</tbody>
</table>
### Pulmonary Examples

<table>
<thead>
<tr>
<th>Condition</th>
<th>Critical Care Treatment</th>
<th>Non - Critical Care Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute lung injury</td>
<td>High-risk medication monitoring, Mechanical ventilation (CPAP, BiPap, ETT), CPR</td>
<td>Postop ventilation that is being weaned</td>
</tr>
<tr>
<td>Acute respiratory distress</td>
<td>High-risk medication monitoring, Mechanical ventilation (CPAP, BiPap, ETT), CPR</td>
<td>Postop ventilation that is being weaned</td>
</tr>
<tr>
<td>Acute respiratory failure</td>
<td>High-risk medication monitoring, Mechanical ventilation (CPAP, BiPap, ETT), CPR</td>
<td>Postop ventilation that is being weaned</td>
</tr>
<tr>
<td>Asthma exacerbation (severe)</td>
<td>High-risk medication monitoring, Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Routine vital sign checks for critically ill patient, Oral prescriptions/inhalers</td>
</tr>
<tr>
<td>Cardiogenic shock without mention of trauma</td>
<td>High-risk medication monitoring, Pressors, Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Routine vital sign checks for critically ill patient, Oral prescriptions</td>
</tr>
<tr>
<td>Circulatory failure</td>
<td>High-risk medication monitoring</td>
<td>Routine vital sign checks for critically ill patient</td>
</tr>
<tr>
<td>COPD exacerbation (severe)</td>
<td>High-risk medication monitoring, Mechanical ventilation (CPAP, BiPap, ETT)</td>
<td>Routine vital sign checks for critically ill patient, Oral prescriptions/inhalers</td>
</tr>
</tbody>
</table>
## Commonly Used Critical Care Infusions

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Fluid</th>
<th>To yield</th>
<th>Calculation Constant</th>
<th>Usual Dose Range</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dopamine (Inotropin)</td>
<td>400 mg</td>
<td>D5W 250cc</td>
<td>1.6 mg/cc</td>
<td>26.7 mcg/mcg</td>
<td>2 - 20 mcg/kg/min</td>
<td>&lt;3 mcg renal dose</td>
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<td>7 mcg begins to</td>
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<td>impair renal</td>
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<td>circulation.</td>
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<tr>
<td>Sodium Nitroprusside</td>
<td>50 mg</td>
<td>D5W 250cc</td>
<td>0.2 mg/cc</td>
<td>3.3 mcg/mcg</td>
<td>0.5 - 8 mcg/kg/min</td>
<td>1) Protect from</td>
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<tr>
<td>(Nipride)</td>
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<td>light</td>
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<td>2) Monitor serum</td>
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<td>Thiocyanate</td>
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<td>levels.</td>
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<tr>
<td>Dobutamine (dobutrex)</td>
<td>250 mg</td>
<td>D5W 250cc</td>
<td>1 mg/cc</td>
<td>16.7 mcg/mcg</td>
<td>2.5 - 10 mcg/kg/min</td>
<td>Inotropic Agent</td>
</tr>
<tr>
<td>Epinephrine (Adrenalin)</td>
<td>2 mg</td>
<td>D5W 250cc</td>
<td>8 mcg/cc</td>
<td>0.13 mcg/mcg</td>
<td>1 - 4 mcg/min</td>
<td>Large doses</td>
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<td>vasodilation</td>
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<td>Small doses</td>
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<td></td>
<td></td>
<td></td>
<td>vasodilation</td>
</tr>
<tr>
<td>Isoproterenol (Isuprel)</td>
<td>2 mg</td>
<td>D5W 250cc</td>
<td>8 mcg/cc</td>
<td>0.13 mcg/mcg</td>
<td>2 - 10 mcg/min</td>
<td>Use with caution</td>
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<td>in patients who</td>
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<td>VPCs. Increases</td>
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<td>possibility of</td>
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<td>VT/VF.</td>
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<tr>
<td>Norepinephrine</td>
<td>2 mg</td>
<td>D5W 250cc</td>
<td>8 mcg/cc</td>
<td>0.13 mcg/mcg</td>
<td>2 - 12 mcg/min</td>
<td>May be titrated</td>
</tr>
<tr>
<td>(Levophed)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>to higher doses</td>
</tr>
<tr>
<td>Phenylephrine</td>
<td>20 mg</td>
<td>D5W 250cc</td>
<td>80 mcg/cc</td>
<td>1.3 mcg/mcg</td>
<td>10 - 20 mcg/min</td>
<td>Higher doses may</td>
</tr>
<tr>
<td>(Neo syphrine)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>be ordered</td>
</tr>
<tr>
<td>Amrinone</td>
<td>500 mg</td>
<td>NS100cc to make 200cc volume</td>
<td>2.5 mcg/cc</td>
<td>41.7 mcg/mcg</td>
<td>2 - 20 mcg/min</td>
<td>Loading dose 0.75 mcg/kg. Must be mixed in NS or 4.5 NS</td>
</tr>
<tr>
<td>Nitroglycerin (Tridil)</td>
<td>50 mg</td>
<td>D5W 250cc</td>
<td>200 mcg/cc</td>
<td>3.33 mcg/mcg</td>
<td>5 - 200 mcg/min</td>
<td>Must be mixed in glass bottle &amp; administered is special tubing</td>
</tr>
<tr>
<td>Lido caine (xyloca ine)</td>
<td>2 Grams</td>
<td>D5W 250cc</td>
<td>8 mcg/cc</td>
<td>0.13 mcg/mcg</td>
<td>1 - 4 mcg/min</td>
<td>Loading dose: 1 mg/kg up to 3 mg/kg</td>
</tr>
<tr>
<td>Procanamide (Pronesty l)</td>
<td>2 Grams</td>
<td>D5W 250cc</td>
<td>8 mcg/cc</td>
<td>0.13 mcg/mcg</td>
<td>1 - 4 mcg/min</td>
<td>Loading Dose: 20 mg/min up to 1 gram</td>
</tr>
</tbody>
</table>
# Common Critical Care IV Meds

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Dilution</th>
<th>Rate</th>
<th>Loading Dose</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRETYLIUM (Brevylol)</td>
<td>2 Grams</td>
<td>DSW 250cc</td>
<td>8 mg/cc</td>
<td>1 - 2 mg/min</td>
<td>Loading Dose: 5 mg/kg up to 30 mg/kg</td>
</tr>
<tr>
<td>Vaso depressin (Pitressin)</td>
<td>200 IU</td>
<td>DSW 250cc</td>
<td>0.8 units/cc</td>
<td>0.2 - 0.4 units/min</td>
<td>Must be aqueous pitressin</td>
</tr>
<tr>
<td>Labetalol (Trandate)</td>
<td>300 mg</td>
<td>DSW 240cc to make 300cc total volume</td>
<td>1 mg/cc</td>
<td>2 mg/min</td>
<td>Loading Dose: 20 mg up to 80 mg</td>
</tr>
<tr>
<td>Esmolol (Brevibloc)</td>
<td>5 Grams</td>
<td>DSW 500cc</td>
<td>10 mg/cc</td>
<td>50 - 200 mcg/kg/min</td>
<td>Short acting Beta Blocker</td>
</tr>
<tr>
<td>Diltiazem (Cardizem)</td>
<td>125 mg</td>
<td>DSW 100cc as to make 125cc volume</td>
<td>1 mg/cc</td>
<td>10 - 15 mg/hr</td>
<td>Can also be used for atrial arrhythmias &amp; SVT</td>
</tr>
<tr>
<td>Heparin</td>
<td>25,000 units</td>
<td>DSW 250cc</td>
<td>100 units/cc</td>
<td>---</td>
<td>Given based on protocol, adjusted per nomogram based on PTT</td>
</tr>
<tr>
<td>Insulin</td>
<td>100 units</td>
<td>NS 100cc</td>
<td>1 unit/cc</td>
<td>---</td>
<td>Watch for hypoglycemia</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>450 mg</td>
<td>250 cc</td>
<td>----</td>
<td>1 mg/min for 6 hours @33 cc/hr</td>
<td>Watch for hypotension</td>
</tr>
<tr>
<td>Propofol (Diprivan)</td>
<td>1000 mg</td>
<td>100cc</td>
<td>10 mg/cc</td>
<td>b/c rate to sedation</td>
<td>Control according to Ramsay sedation scale</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>167mcg/mcg/kg</td>
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</tr>
</tbody>
</table>
# Critical Care Time

<table>
<thead>
<tr>
<th>Total Duration of Critical Care</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>Appropriate E/M codes (9923X or 9925X)</td>
</tr>
<tr>
<td>30-74 minutes (1/2 hr. – 1 hr. 14 min.)</td>
<td>99291 X 1</td>
</tr>
<tr>
<td>75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)</td>
<td>99291 X 1 and 99292 X 1</td>
</tr>
<tr>
<td>105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.)</td>
<td>99291 X 1 and 99292 X 2</td>
</tr>
<tr>
<td>135-164 minutes (2 hr. 15 min. – 2 hr. 44 min.)</td>
<td>99291 X 1 and 99292 X 3</td>
</tr>
<tr>
<td>165-194 minutes (2 hr. 45 min. – 3 hr. 14 min.)</td>
<td>99291 X 1 and 99292 X 4</td>
</tr>
<tr>
<td>194 minutes or longer (3 hr. 14 min. – etc.)</td>
<td>99291 and 99292 as appropriate</td>
</tr>
</tbody>
</table>

**99291**: first 30-74 minutes. Report only once per calendar day per provider/same specialty group. May not be combined with NPP or resident time. 9923X or 9925X for less than 30 minutes.

**99292**: each additional 30 minutes beyond 74. May be aggregated time met by one provider or same group/specialty.
Neonatal Critical Care Services

• CPT Codes 99477 to 99480
• Critical care services are reported per day
• Requires intensive observation, frequent interventions, and other intensive care services
Neonates: Two New Codes Added in 2014

• In CPT 2014, two new codes were added to the inpatient neonatal and pediatric critical care services (99466-99482) to describe total body and selective head hypothermia procedures, performed on neonates who experience serious hypoxia and ischemia (eg, hypoxic-ischemic encephalopathy [HIE]) at or shortly after delivery. These services may offer a neuroprotective effect on neonates who have experienced a serious HIE event threatening their intact neurodevelopmental survival.

• ✚●99481Total body systemic hypothermia in a critically ill neonate per day (List separately in addition to code for primary procedure)

• ✚●99482Selective head hypothermia in a critically ill neonate per day (List separately in addition to code for primary procedure)
Reportable Time

- Report critical care for time spent engaged in work directly related to patient’s care at bedside or elsewhere on floor or unit, only if:
  - Physician is immediately available and giving full attention to patient management.
  - Physician may not be involved in any other patient’s care during time reported.
  - Time is 30 minutes or greater on that day by one provider.
- No services may be reported for any other patients concurrently during same period of time.
- CC time may not be combined with NP/PA’s or resident’s time.
- Time counted toward critical care services may be continuous or intermittent and aggregated.
- Physicians of the same group practice may bill as though they were a single physician.
- Time excludes time billing provider spent rendering other billable procedures, teaching or NP/PA/Resident time rendering care.
Reportable Time

Only one physician may bill for critical care during any one single period of time, even if more than one physician is providing care (you would be side-by-side.) Exception to trauma services for “overlap” if each attending is addressing distinct issues and “share” the time.

- Example of physician activities that may be counted towards critical care time even though services may not occur at bedside but are provided on the patients floor:
  - reviewing test results or imaging studies at nursing station
  - discussing patient’s care with other medical staff on floor
  - documenting critical care services in medical record while on floor
  - obtaining history &/or making plans with family members, if patient is unable to do so.
Time Spent With Family Members

When patient is unable or clinically incompetent to participate in discussions, time spent on floor/unit or phone calls made from floor/unit with family members or surrogate decision makers may be reported as part of critical care time if it involves:

• Obtaining needed medical history
• Reviewing the patient's condition or prognosis
• Discussing treatment or limitation(s) of treatment
• The conversation must bear directly on the management of patient and must be medically necessary for determining treatment decisions.

Provider must document:

• Patient’s inability to participate in giving history and/or making treatment decisions
• Necessity for the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with family")
• Information obtained or decisions made.

Note: Time to provide routine daily updates or reports to family members and/or surrogates cannot be included in critical care time no matter how lengthy.
Critical Care Documentation From Attending Teaching Physician

INCLUDE:

- **Critical nature of patient’s condition** should be accurately documented to support the medical necessity of 1 to 1 services.

- **Nature of all problems being managed, particularly those related to organ system failure.** If stabilized, document ongoing critical status if applicable.

- **All organ sustaining interventions** requiring direct physician assessment and interventions.

- **Complexity of medical decision making**

- **Patient assessment**

- **Substance of family discussions as billable CC time**, if applicable.

- **Billing provider’s time spent evaluating, managing and providing CC services exclusive of procedure, resident and NPP time.** Aggregation of time spent by the billing provider (if applicable)
Suggestions to avoid denials:

- **Use of personal pronouns.** This clarifies what the provider did that qualifies as critical care even if the treatment and settings remain constant.

- **Use verbs** to indicate what was done that day.

- **Use accurate phrasing** that shows intervention rather than ultimate result of intervention.
  - Stable vs. hemodynamically acceptable due to stated actions personally performed
  - Stable on pressors vs consistently on pressors
  - Stable on a PC of 30 vs consistently requiring ventilator
  - Stable on balloon pump vs consistently requiring balloon pump

*“Stable”, “Improving”, “Transferring”* does not support that the patient is critically ill in the eyes of many auditors.
Watch for These Terms Which May Be Key Indicators of Critical Care

Acidosis
Anaphylactic shock
Angina, unstable, aggressive management
Atrial fibrillation with tachycardia
Asthma, multiple treatments with more risk
Blood loss, PRBCs hung, GI bleed
Cardiac arrest
Comatose/unconscious, unknown cause at presentation
COPD/CHF severe exacerbation
Dehydration with significant metabolic/blood chemistry changes
Glasgow Coma Scale below 14
Head injury, severe, unresponsive
Hypoxia/hypoxemia
Unstable vital signs
Hypernatremia
Open fracture
Pneumothorax
Pulmonary edema, or emboli
Rapid heart rate requiring IV therapies and/or close monitoring in ED
Seizure, new onset or with disorder hx, postictal with intensive drug management
Sepsis/septicemia
Severe bleeding, requiring transfusion
Shock-unresponsive patient
Status Asthmaticus
Status Epilepticus
Stroke
Suicidal ideation, clear and immediate threat, requiring chemical/physical restraints
Trauma, multiple, altered consciousness, life or limb threatened
Signs of Aggressive Management

**Anti-arrhythmics:** adenocard, adenosine, atropine, bretylium, Cardizem, Inderal, lidocaine, magnesium sulphate, procainamide, verapamil, et.al;

**Pressors:** dobutamine, dopamine, epinephrine, Levophed, Lopressor

**Vasodilators:** nitro, Nipride, et.al.

**Others:** aminophylline, diazepam, glucagon, morphine, sodium bicarb

**Procedures:** endotracheal intubation/RSI, CPR, CPAP, thrombolytic therapy (TPA for cardiac or stroke) cardioversion, defibrillation, thoracostomy, thoracentesis, pericardiocentesis, CVP insertion, tracheostomy, cricothyroidotomy, abdominal paracentesis, etc.
Supporting Documentation: Critical care must be medically necessary; involve high complexity decision making

- Was the physician called to see the patient on an emergency basis?
- Does the physician’s note support evidence of threat of imminent deterioration of patient’s condition?
- Is the critical illness or injury acutely impairing one or more body systems?
- Was the physician’s services required to prevent further decline of a life threatening condition?
- Does the documentation indicate that an assessment of the patient and services of the physician were provided to support vital system function?
Examples of CC Documentation Relative to Respiratory Failure Interventions

- **Acute Hypoxic Respiratory Failure**
  - Intubated last evening; sedated. Will continue patient on vent (volume control) following ARDS guidelines. Orders placed for ABGs and daily CXR.
- **Acute Hypoxic Respiratory Failure**
  - Adjusted vent settings & sedation today in hopes of beginning weaning tomorrow – expected to be challenging given underlying COPD.
- **Discussed signs of imminent renal failure with Nephrology who recommends beginning dialysis.**
- **Acute Respiratory Failure**
  - Continue daily SBT and sedation holiday. Continue MV to maintain compensated ABGs—will try PS ventilation.
- **Hypoxic Resp failure**
  - Pt extubated this morning; on BiPAP, with RR in 30s. Continue BIPAP, but adjust to get TV $\geq 350$. Low threshold to re-intubate; will monitor closely.
Examples of Critical Care Documentation relative to Respiratory Failure Interventions

Hypoxic Respiratory Failure
- “Due to either volume overload (most likely) or to aspiration. I have adjusted the patient’s BiPap to provide more PEEP to counteract the pulmonary edema. As this seem to have helped, we will hold off on intubating the patient at this time, but will need to do so if respiratory condition worsens”

Respiratory Failure with hemoptysis
- “ABG: 7.44/36/71/24 Lactate 0.6”
- “On vent, with propofol/fentanyl gtt; po2 low, will increase fiO2/PEEP to titrate po2 > 60”
- “Possible PE, though unclear; will continue empiric abx for HCAP”

Acute Hypoxic Respiratory Failure:
- “I evaluated vent settings at bedside. Placed on PSV but failed 2/2 inadequate MVe/RSBI, still mild flow trapping on vent and better but restricted expiratory air movement on exam.”
Post Operative Encounters in the ICU

Usual postoperative care in an intensive care unit is inclusive to the global surgical payment and may not be billed separately. Code 99024 (Post operative Care) may be reported.

- Separate billing for encounters in the post-operative period is allowed for:
  - Encounters unrelated to the specific anatomic injury or general surgical procedure performed. A diagnosis code which clearly indicates that the service is unrelated to the surgery is required.
  - Unusual complications of the surgery.
  - Treatment for the underlying condition or an added course of treatment which is not part of normal recovery.
  - Critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician/NPP.

- If the unrelated encounter further meets the criteria for critical care then further documentation to support time is 30 minutes or greater, critical condition and critical treatment is required.
Physicians in the Same Group Practice

- Physicians in same group practice who have same specialty may not each report 99291 (first 30-74 minutes) for same patient on same calendar date. Total aggregated time of multiple physicians in the same group/same specialty may be used to calculate overall critical care time.

- Follow-up services after the first 74 minutes may be billed by another provider with the same specialty as 99292.

- Physicians in same group practice with different specialties:
  - May bill separately if:
    - Each provider provided care unique to his/her medical specialty
    - Managed at least one of patient’s critical illness(es)/injury(ies)
    - Critical care requirements have been met
    - Time did not overlap with other providers’ billing
Concurrent Care- Only One Claim per Aspect of Care

• Concurrent care by more than one physician, different physician specialties, is payable if the services all meet critical care requirements, are medically necessary, and are not duplicative (refer to Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services) for concurrent care policy discussion).
  • Page 14 of 293

• The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient’s treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.
Concurrent Care- Only One Claim Per Aspect of Care

In order to determine whether concurrent physicians’ services are reasonable and necessary, the carrier must decide the following:

1. Whether the patient’s condition warrants the services of more than one physician on an attending (rather than consultative) basis, and
2. Whether the individual services provided by each physician are reasonable and necessary.

The carrier should consider the specialties of the physicians as well as the patient’s diagnosis, as concurrent care is usually (although not always) initiated because of the existence of more than one medical condition requiring diverse specialized medical or surgical services.

The specialties of the physicians are an indication of the necessity for concurrent services, but the patient’s condition and the inherent reasonableness and necessity of the services, as determined by the carrier’s medical staff in accordance with locality norms, must also be considered.
Billing Example
Two Physicians With Different Specialty

• Dr. Brown pulmonologist performs 45 minutes critical care
• Dr. Jones cardiologist in same practice performs 40 minutes critical care on same day.

• Billing:
  • Dr. Brown bills 99291
  • Dr. Jones could bill 99291 as long as the time he saw the patient was not at the same time Dr. Brown saw the patient.
Services Included in Critical Care Codes

• Interpretation of cardiac output measurements (93561, 93562)
• Interpretation of chest x-rays, (71010, 71015, 71020)
• Pulse oximetry (94760, 94761, 94762)
• Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data) (99090)
• Gastric intubation 43752, 43753)
• Temporary transcutaneous pacing (92953)
• Ventilator management (94002-94004, 94660, 94662)
• Vascular access, arterial puncture (36000, 36410, 36415, 36591, 36600)
Separately Billable Services With CC

Any procedure or service, not specifically listed as included in 99291/99292.

Examples:
- Endotracheal intubation (31500)
- Arterial line placement (36620)
- Central line placement (36556)
- Placement of a flow directed catheter, e.g., Swan-Ganz (93503)
- EKG interpretation (NOT Rhythm strips)
- CPR (92950)

Do not include time for performing billable procedures in critical care time. Include a statement such as:

- “Critical Care time does not include the time to perform……”

Modifier -25 must be appended to critical care service code to indicate that critical care was a significant, separately identifiable E/M service above and beyond the usual pre and post operative care associated with procedure performed.
Subsequent hospital care codes; 99231-99233

- Hospital Consultation 99251-99255
  - For Medicare, consultations are converted internally to Initial or subsequent Hospital Visits

- ED Consultation 99241-99245

Or

- Ventilator Management codes;
  94002 Ventilation assist and management; initiation – First Day
  94003 subsequent Day
**Subsequent Hospital Care:**

*2 of the 3* criteria (Hx, Exam, MDM) must be met for that level

<table>
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<tr>
<th>2 of 3</th>
<th>History</th>
<th>Exam</th>
<th>Medical Decision Making Points (need 2 of 3)</th>
<th>Usually patient is:</th>
<th>Typical Time</th>
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<tbody>
<tr>
<td>99231</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straight Forward</td>
<td>Stable, recovering, improving.</td>
<td>15 min</td>
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<tr>
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<td>HPI: 1-3</td>
<td>95: 1 BA/OS</td>
<td>Dx/Tx options: 1</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>ROS: none</td>
<td>or 97: 1-5 bullets</td>
<td>Amt/Complex data: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PFSH: none</td>
<td>Risk: 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99232</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Moderate Complexity</td>
<td>Responding inadequately to therapy or has developed minor complication</td>
<td>25 min</td>
</tr>
<tr>
<td></td>
<td>HPI: 1-3</td>
<td>95: 2-7 OS or BA limited</td>
<td>Dx/Tx options: 3</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>ROS: 1</td>
<td>or 97: &gt;6 bullets</td>
<td>Amt/Complex data: 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PFSH: none</td>
<td>Risk: Moderate 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High Complexity</td>
<td>Unstable or has developed a significant complication or significant new problem.</td>
<td>35 min</td>
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<td>HPI: 4+</td>
<td>95: 2-7 OS or BA extended</td>
<td>Dx/Tx options: 4</td>
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<td>or 97: &gt;2 bullets from 6 areas</td>
<td>Amt/Complex data: 4</td>
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<td></td>
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<tr>
<td></td>
<td>PFSH: 2</td>
<td>or &gt;12 bullets from &gt;2 areas</td>
<td>Risk: High</td>
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</table>
Guidelines for Teaching Physicians (TP) When Working With Residents Fellows and Interns

For Billing Services, All Types of Services Involving a TP Requires Appropriate Attestations In EHR or Paper Charts
Teaching Physicians (TP) Critical Care

- TP must be present for entire time represented by code billed.
- TP time may **not** include:
  - Time spent by resident without TP present
  - Teaching time
  - Time performing billable procedures.
- Although TP cannot bill for time spent by ACGME resident/fellow providing CC services in their absence, TP’s documentation may tie & refer to resident’s documentation for specific patient history, physical findings and medical assessment.
- TP’s own note must provide substantive information:
  - Time TP spent providing critical care.
  - That patient was critically ill during time TP saw the patient
  - What patient’s critical illness is.
  - Nature of treatment and management provided by TP.
  - Face-to-Face by the attending.
Acceptable Documentation Examples:

"Patient developed hypotension and hypoxia; I spent 30 minutes, excluding time resident was alone with the patient, teaching time and procedural time, while patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with resident's assessment and plan of care."

“Patient seen and examined with Dr. Resident. Reviewed and agree with his note and plan of care developed together. I **personally** spent 45 minutes, excluding resident teaching time and procedural time, performing critical services due to patient’s hemo-dynamic instability. Patient was resuscitated with 2 units of packed red blood cells. Additional studies were obtained to determine possible causes for patient’s instabilities.”
What Is First Coast Services Option – Our Carrier, Doing Now?

• [http://medicare.fcso.com/Medical_review/0327876.asp](http://medicare.fcso.com/Medical_review/0327876.asp)

• In response to continued Comprehensive Error Rate Testing (CERT) errors and risk of improper payments, First Coast will implement a prepayment threshold edit for CPT® code 99291 claims submitted on or after March 15, 2016, that will apply to all providers within First Coast’s Florida jurisdiction.
Recent data analysis pertaining to critical care services has identified that First Coast is at a high risk for claim payment error. First Coast continues to have a high comprehensive error rate testing (CERT) error rate related to utilization of CPT® code 99291. Errors include incorrect coding and/or insufficient documentation to support code 99291, which is defined in the Current Procedural Terminology (CPT®) code 99291 manual as follows:

**First Coast response**

- In response to continued CERT errors and risk of improper payments First Coast will implement a prepayment threshold edit for CPT® code 99291 claims submitted on or after March 15, 2016, that will apply to all providers within First Coast’s Florida jurisdiction.
Resources


• CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Publication 100-04,
  • Chapter 12, section 30.6.9 and 30.6.12
  • Chapter 4, section 160.1

• CMS Internet Only Manual (IOM Benefit Policy Manual, Publication 100-02, Chapter 15, Section 30. E
  • Last Updated Dec 2, 2015
Evaluation and Management (E/M)

E/M IP or OP: TP must personally document by a personally selected macro in the EMR or handwritten at least the following:

- That s/he was present and performed key portions of the service in the presence of or at a separate time from the resident; AND
- The participation of the teaching physician in the management of the patient.

- Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with an upper respiratory infection not pneumonia. Will begin treatment with........”

- Initial or Follow-up Visit: “I saw and evaluated the patient. Discussed with resident and agree with resident’s findings and plan as documented in the resident’s note.”

- Follow-up Visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”

- Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note, but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

The documentation of the Teaching Physician must be patient specific.
Evaluation and Management (E/M)

**Time Based E/M Services:** The TP must be present and document for the period of time for which the claim is made. Examples:

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care

*Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical student must be re-performed and documented by a resident or teaching physician.*
**Minor** – (< 5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is **physically present during the entire procedure**.

  Example: ‘I personally performed the procedure’
  Example: ‘I was present for the entire procedure.’
Diagnostic Procedures

• **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**

  • **General Rule:** The Teaching Physician may bill for the interpretation of diagnostic Radiology and other diagnostic tests if the interpretation is performed or reviewed by the Teaching Physician with modifier 26 in the hospital setting.

• **Teaching Physician Documentation Requirements:**
  • Teaching Physician prepares and documents the interpretation report.
  • OR
  • Resident prepares and documents the interpretation report
  • The Teaching Physician must document/dictate: “I personally reviewed the film/recording/specimen/images and the resident’s findings and agree with the final report”.

• A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.
Minor Procedure With an E/M
Modifier 25 – Be ALERT

- Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.
  - The patient’s condition required a significant, separately identifiable E/M service, *above and beyond* the usual pre- and post-procedure care associated with the procedure or service performed.
  - The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, *different diagnoses are not required* for reporting of the E/M services on the same date.

- The service could be a minor procedure, diagnostic service, E/M visit with a preventive service or E/M with a Medicare Well Visit or Well-Woman service.

- It is *STRONGLY* recommended that 2 separate and distinct notes be included in the medical record to document the procedure and then the separate E/M service.

- Only a practitioner or coder should assign a modifier 25 to a Claim – Not a biller.
Modifier 25 – Be ALERT

• When Not to Use the Modifier 25
• When billing for services performed during a postoperative period if related to the previous surgery
• When there is only an E/M service performed during the office visit (no procedure done)
• When on any E/M on the day a “Major” (90 day global) procedure is being performed
• When a minimal procedure is performed on the same day unless the level of service can be supported as significant, separately identifiable. All procedures have “inherent” E/M service included.
• When a patient came in for a scheduled procedure only
Top Compliance Issues For Documenting in EMR
PAYORS ARE WATCHING EMR DOCUMENTATION

Once you sign your note, YOU ARE RESPONSIBLE FOR ITS CONTENT
Top Compliance Rules for EMR

Use “Copy Forward” with caution

• Each visit is unique

• **Cloned documentation** is very obvious to auditors

• If you bring a note forward it MUST reflect the activity for the CURRENT VISIT with appropriate editing

• **Strongly advise** NOT copying forward HPI, Exam, and complete Assessment/Plan
Top Compliance Rules for EMR

Don’t dump irrelevant information into your note

• (“the 10-page follow-up note”)

• Be judicious with “Auto populate”
• Consider Smart Templates instead
• Marking “Reviewed” for PFSHx or labs is OK from Compliance standpoint (as long as you did it!)
Top Compliance Rules for EMR

Never copy ANYTHING from one patient’s record into another patient’s note

• Self-explanatory
Top Compliance Rules for EMR

Only Past/Family/Social History and Review of Systems may be used from a *medical student* or *nurse’s* note

- Student or nurse may start the note
- Provider (resident or attending)
- must document HPI, Exam, and
- Assessment/Plan
Top Compliance Rules for EMR

Be careful with pre-populated “No” or “Negative” templates

- Cautious with ROS and Exam
- Macros, Check-boxes, or Free Text are safer and more individualized
Top Compliance Rules for EMR

Link diagnosis to each test ordered (lab, imaging, cardiographics, referral)

• Demonstrates Medical Necessity

• Know your covered diagnoses for your common labs
Copy/Paste Philosophy:

*Your note should reflect the reality of the visit for that day*
Use Specific Dates

• Don’t say Today, Tomorrow, or Yesterday

• Write specific dates, i.e., “ID Consult recommends ceftriaxone through 9/3”, instead of “six more days”, which could be carried forward inaccurately

• “Heparin stopped 6/20 due to bleeding” will always be better than “Heparin stopped yesterday”, which can be carried forward in error
Use Past Tense

- "Neuro status remains stable, will discontinue neuro checks" can be copied forward in error.

- Better – "Neuro checks stopped on 2/24"

- "Added heparin on 4/26" – uses past tense and specific date for better accuracy.
Copy / Paste Summary

• Copy/Paste can be a valuable tool for efficiency when used correctly

• There are major Compliance risks when used inappropriately, including potential fraud and abuse allegations, denial of hospital days, and adverse patient outcomes

• Make sure your note reflects the reality and accuracy of the service each day
"I hear there's a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system."
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  -- Do not include PHI in text messages!!
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!

• Never share your password with anyone and no one use someone else’s password for any reason, ever – even if instructed to do so.

✓ If asked to share a password, report immediately.
✓ If you haven’t completed the HIPAA Privacy & Security Awareness on-line CBL module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development_training_office/learning/ulearn/
Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

What is Fair Warning?

• **Fair Warning** is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.

• **Fair Warning** protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.

• **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA auditing.

UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: [http://www.med.miami.edu/hipaa](http://www.med.miami.edu/hipaa)
“Whoa—way too much information.”
Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - **Helenmarie Blake-Leger, Interim AVP of Compliance & Chief Privacy Officer**
    - Phone: (305) 243-6000
  - **Iliana De La Cruz, RMC, Director Office of Billing Compliance**
  - **Gema Balbin-Rodriguez, Associate Director Office of Billing Compliance**
    - Phone: (305) 243-5842
    - Email: Officeofbillingcompliance@med.Miami.edu

Also available is The University’s fraud and compliance hotline via the web at [www.canewatch.ethicspoint.com](http://www.canewatch.ethicspoint.com) or toll-free at 877-415-4357 (24 hours a day, seven days a week). Your inquiry or report may remain anonymous.

- Office of billing Compliance website: [www.obc.med.miami.edu](http://www.obc.med.miami.edu)