Teaching Physician Attestation

If a resident participates in a service provided in a teaching setting, the teaching physician may not bill Medicare for such services unless the teaching physician is present during or personally performs the key portion(s) of any services for which payment is sought. The Teaching Physician does not need to repeat, in detail, the key elements of the service personally obtained by the resident. Rather, the documentation of the Teaching Physician may be brief, summarizing the components that tie into the resident’s entry and which confirm, add or revise the key elements, the History, Exam and Medical Decision Making and personally adding his/her attestation.

PHYSICIAN’S VERIFICATION OF PRESENCE IN THE UMCARE SYSTEM IN ALL FACILITIES, WHERE AVAILABLE, IS REQUIRED IN ORDER TO COMPLY WITH THE MEDICARE RULE FOR TEACHING PHYSICIANS. Policy available at www.abc.med.miami.edu.

Co-Surgery Modifier (62)

Under some circumstances, the individual skills of two physicians are required during the same operative session. This may be required because of the complex nature of the procedure(s) and/or patient’s condition. In these cases, the physicians are acting as co-surgeons.

When two surgeons work together as primary surgeons performing distinct part(s) of a single billable procedure, each surgeon must bill his/her distinct operative work by adding modifier 62 to the procedure performed.

There are two categories of surgical procedures for which co-surgery may be covered:

The first category identifies procedures that may be allowed when:

- the specialties of the physicians are the same
- the surgical procedure performed (same procedure code)

the procedure is considered medically necessary

Claims for these procedures must include an operative report for which supports the need for co-surgeons. If each surgeon’s role is explicitly described during the operative session, then only one operative report is necessary. Otherwise, an operative report dictated by each surgeon is required.

The second category identifies procedures which may be allowed when:

- the specialties of the co-surgeons are different
- the same surgical procedure is performed (same procedure code)

When co-surgery payment rules apply, each surgeon will be allowed 62.5% of the fee schedule amount for the highest procedure.

For multiple surgeries, the reimbursement for each additional procedure is allowed at 50% of the 62.5% of the fee schedule allowance for the second through the fifth procedures.

Surgical procedures to which co-surgery rules apply must be billed by each surgeon with the same date of service, the same procedure code and Modifier 62 (co-surgery).
Anesthesiology

Ten Teaching and Payment Scenarios for Anesthesia

1) **1 MD + 1 Resident** = MD paid 100% of the allowed amount

2) **1 MD + 2 Residents in two separate concurrent cases** = MD paid 100% of the allowed amount for each case

3) **1 MD + 1 Resident + medical direction of 1 CRNA in two separate concurrent cases** = MD paid 100% of the allowed amount for the resident case and 50% of the allowed amount for the CRNA case. CRNA paid 50% of the allowed amount for his/her case

4) **1 MD + 2 SRNAs in two separate concurrent cases** = MD paid 50% of the allowed amount for each case (Note: MDs cannot be involved in more than two concurrent SRNA cases without a CRNA also involved)

5) **1 MD medically directing 1 CRNA + 1 SRNA (CRNA teaching SRNA in same case)** = MD paid 50% of the allowed amount, CRNA paid 50% of allowed amount

6) **1 MD medically directing 1 CRNA + 1 SRNA in two separate concurrent cases** = MD paid 50% of the allowed amount for each case, CRNA paid 50% of the allowed amount for his/her case. No payment made for the SRNA service

7) **1 Non-medically directed CRNA + 1 SRNA** = CRNA paid 100% of the allowed amount

8) **1 Non-medically directed CRNA + 2 SRNAs in two separate concurrent cases** = CRNA paid 100% of the allowed amount for each case

9) **1 MD medically directing 1 CRNA + 2 SRNAs in two separate concurrent cases** = MD paid 50% of the allowed amount for each of the 2 cases, CRNA paid 50% of base + face for each case

10) **1 MD medically directing 4 CRNAs, each involved in 1 case with a SRNA** = MD paid 50% of the allowed amount for each of the 4 cases, and each of the 4 CRNAs paid 50% of the allowed amount for the case in which he/she was involved

LABORATORY/PATHOLOGY

MEDICAL NECESSITY

The Centers for Medicare and Medicaid Services (CMS) laws prohibit payment for services and items deemed by local Medicare Carriers as not medically reasonable and necessary for the diagnosis or treatment of an illness or injury. Documentation of "medical necessity" is required in order for the claim to be paid

To comply with these guidelines, physicians should:

- Order tests that are medically necessary in diagnosing or treating their patients;
- Provide or Enter all appropriate and correct ICD-9 diagnosis codes in both their patient files and on the test request forms; and identify laboratory tests and procedures that require additional medical necessity documentation before the laboratory can be reimbursed.
- LCDs outline how Medicare will review claims to determine if coverage requirements have been met.
- NOTE: Obtain the patient’s signature and date on an Advance Beneficiary Notice (ABN), when you believe the service is likely to be denied.

Click on link, below
New waived tests
Billing and Coding Guidelines

Click on the links below for guidelines

Delay in implementing NCD for single chamber and dual chamber cardiac pacemakers

The July 7, 2014, implement date for national coverage determination (NCD) 20.8.3 is temporary being delayed. CMS will advise of the new implementation date in the near future.

Ultrasound guidance for needle placement in the office setting and Minimum criteria for reimbursement of diagnostic ultrasound tests.

In the 2014 proposed rule for Revisions to Payment Policies under the Physician Fee Schedule, CMS proposes a reduction in the relative value units (RVUs) based on equipment inputs and procedure time assumptions for CPT® code 76942 (Ultrasound guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation). Medicare of Florida’s prior guidance of recoding of 76942 to an unlisted procedure code has been rescinded and claim adjustments will be performed. However, services that were previously denied as not reasonable and necessary for an ultrasound guidance service will remain denied. Click on the link, below.

Billing and Coding Procedure 76942

Draft LCDs

Click on the links below to access the LCDs

Draft LCD for Varicose Veins of the Lower Extremities

Varicose veins of the lower extremity

Application of Skin Substitute Grafts for Treatment of DFU and VLU of Lower Extremities; click on the link, below

Application of Skin Substitute Grafts for Treatment of DFU and VLU of Lower Extremities

LCDs and MLN Matters Articles

Click on the links below to access the articles:

Transcranial Magnetic Stimulation for Major Depressive Disorder

Transcranial Magnetic Stimulation for Major Depressive Disorder

Documenting Medical Necessity for Major Joint Replacement (Hip and Knee)


Click on the links below to access the articles:

Cataract removal


Reminder of Importance of Correct Place of Service Coding on Medicare Part B Claims

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be billed unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and bill only one Evaluation and Management code.

Physicians in the same group practice, but who are in different specialties, may each bill and be paid.

**Medically Unlikely Edit (MUE) and Bilateral Surgical Procedures**

The Centers for Medicare & Medicaid Services (CMS) completed a review of medical unlikely edit (MUE) claims data and confirmed a pattern of inappropriate billing for bilateral surgical procedures using multiple lines to bypass the claim edits.

According to CMS, the practice of using multiple lines overcharges both patients and the Medicare program. CMS will begin implementing changes to MUEs for bilateral surgical procedures July 1, 2014. Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a -50 modifier and one unit of service (UOS).

CMS developed MUEs to reduce the paid claims errors for Part B claims. An MUE for a procedure code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.


**MSP (claims denied for other insurance as primary) / Coordination of Benefits**

Before submitting a claim to Medicare:

- Have your patient complete the Medicare Secondary Payer (MSP) Questionnaire to help you determine if Medicare is the primary or secondary payer.
- Check the patient’s eligibility, including if Medicare is a secondary payer, via the interactive voice response (IVR) system or First Coast’s new provider Internet portal, the Secure Provider Online Tool (SPOT).
- If Medicare is secondary, the IVR will list the following MSP details:
  - Type of primary insurance
  - Effective and termination date for all valid Insurers for a current or previous date of service.
- If Medicare is secondary, the SPOT will list the following MSP details:
  - Effective date
  - Termination date
  - Insurer name
  - Policy number
  - Type of primary insurance
  - Address

if any change has occurred in their insurance status. You can complete the Medicare Secondary Payer (MSP) Questionnaire to help you determine if Medicare is primary or secondary. If so, update the insurance information on your files for all future claims.
Ambulatory Surgical Center (ASC) Fee Schedule

The “Ambulatory Surgical Center Fee Schedule” Fact Sheet (ICN 006819) is designed to provide education on the Ambulatory Surgical Center (ASC) Fee Schedule. It includes the following information: the definition of an ASC, ASC payment, how payment rates are determined, and Ambulatory Surgical Center Quality Reporting Program.

Click on the above link to access the Fee Schedule

Telehealth Services Fact Sheet

The “Telehealth Services” Fact Sheet (ICN 901705) is designed to provide education on services furnished to eligible Medicare patients via a telecommunication system. It includes information about originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, billing and payment for the originating site facility fee, resources, and lists of helpful websites and Regional Office Rural Health Coordinators.

2015 PQRS Payment Adjustment

Section 1848(a)(8) of the Social Security Act, requires the Centers for Medicare & Medicaid Services (CMS) to subject eligible professionals and group practices who do not report data on Physician Quality Reporting System (PQRS) quality measures for covered professional services during the 2013 program year for a payment adjustment beginning in 2015. Eligible professionals and group practices receiving a PQRS payment adjustment in 2015 will be paid 1.5% less than the PFS amount for services rendered January 1-December 31, 2015.

Children’s Medical Services Network (CMSN) Managed Medical Assistance (MMA) Notice

With the implementation of the CMSN managed care plan (MCP) on August 1, 2014, please note that Medicaid authorization, formulary, and claims requirements also apply to CMSN MMA plan.

Medicaid Vision Services

Refractions

Medicaid will reimburse only two refractions performed in the provider’s office per recipient, per 365 days. The 365-day period begins with the date of the first refraction.

Computerized Corneal Topography

Computerized corneal topography is reimbursed up to a maximum of four times per year, per patient.

Billing the Correct Date of Service

Providers must not submit a claim for fitting, dispensing, and adjustment of eyeglasses or any other procedure code for eyeglasses, until the patient has been satisfactorily fitted and has taken possession of the eyeglasses.

The provider must use the date that the eyeglasses were dispensed as the date of service on the claim when billing for the eyeglasses (frames, lenses, and add-ons).
Documentation is considered cloned when each entry in the medical record a is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from patient to patient. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

**Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter.**

Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

**COPY AND PASTE EXAMPLES**

- A note was copied “in total to include the PREVIOUS performing provider’s name
- NO original documentation by the “today” provider; just an electronic signature with “today’s date and time”

**ICD-10 NEWS**

**New CMS resource to assist in ICD-10 compliance**

The Centers for Medicare & Medicaid Services (CMS) recently released a new resource to assist practices, particularly smaller organizations, in complying with the requirement to move to ICD-10. **Road to 10** gives practices the capability to build a specialty-specific ICD-10 action plan tailored for the needs of their organization. The specialties covered in the tool include Family Practice, Pediatrics, OB/GYN, Cardiology, Orthopedics and Internal Medicine.

CMS expects to issue a rule in the near future that will officially include the new Oct. 1, 2015 compliance date and require physician practices and other HIPAA-covered entities to continue to use ICD-9-CM through Sept. 30, 2015. The delay to the Oct. 1, 2014 date was included in the Protecting Access to Medicare Act of 2014, which stated that ICD-10 could not be adopted prior to Oct. 1, 2015. To learn more about the transition to ICD-10, visit MGMA’s resource center.
On July 3rd, CMS released its CY 2015 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule, published in the Federal Register on July 14, 2014. The rule proposes revisions to the Medicare Hospital (“OPPS”) payment system, including a fee schedule increase of 2.1%. The rule also proposes revisions to the Medicare (“ASC”) payment system, including a rate increase of 1.2%.

Topics Covered in the 2015 OPPS Proposed Rule

- **Packaging Policies.** CMS proposes to conditionally package certain ancillary services when they are integral, ancillary, supportive, dependent or adjunctive to a primary service. Preventive services will continue to be paid separately. In addition, CMS is not proposing to package certain psychiatry and counseling-related services. CMS is also not proposing to package certain low cost drug administration services.

- **Comprehensive APCs.** CMS proposes to implement comprehensive Ambulatory Payment Classifications (“APC”) with a set of 28 comprehensive APCs that provide a single Medicare payment and single beneficiary copayment for a primary service and all adjunctive services and supplies.

Additional proposals

CMS proposed the packaging threshold to remain at $90, the same as CY 2014, and for the average sales price plus 6% remains in effect for all separately payable drugs, biologicals, and radiopharmaceuticals. CMS proposed no changes to packaging of diagnostic radiopharmaceuticals and contrast agents, or the payment methodology of therapeutic radiopharmaceuticals or brachytherapy for 2015.

To better understand the frequency and type of services furnished in provider-based departments in off-campus locations, CMS proposes a new data collection requirement that, if finalized, would impact both physician and hospital reporting, according to Shah.

Specifically, CMS is proposing to collect this information beginning January 1, 2015, by requiring the use of a new HCPCS modifier that would be reported with every code for physician and outpatient hospital services furnished in an off-campus provider-based department of a hospital.
Hospital inpatient FAQs (click on links below)

Where can I find additional guidance on hospital admission decisions?

Where can I find more information about hospital services?

Should a provider use condition code 44 if the admitting physician decides the patient should be in observation rather than an inpatient setting, and the patient has not been discharged/no claim has been sent yet?

Where can I find information on the new CMS two-midnight rule?

Can lifetime reserve days (LTR) be automatically used if the beneficiary elects not to use them?

Certification of Inpatient Services and E/M Visits

Physician certification of inpatient services

CMS is proposing several changes to requirements related to inpatient physician certification.

Although CMS will continue to require a physician order for inpatient services, it will no longer require certification that the stay was medically necessary in most cases. CMS believes that in most cases the admission order, medical record, and progress notes contain sufficient information to support the medical necessity of an inpatient admission without a separate requirement of an additional, formal, physician certification, with two exceptions.

For stays of 20 days or longer and outlier cases, CMS believes physician certification is needed and therefore proposes to require formal physician certification beyond the admission order to substantiate the medical necessity for these cases.

Hospital Facility Fees/E&M Services

CMS proposed no changes to E/M visit configuration or payment policy methodology in 2015, a year after CMS proposed replacing all E/M visit levels with three HCPCS Level II G-codes. CMS proposes to continue using the single visit G code and existing coding convention for Type A and Type B ED visits, though the agency says it plans on looking at different payment methodologies for the most costly ED trauma-type cases.
Filing an Amended Cost Report

After you have filed an initial cost report, if you find there is a material error that substantially affects reimbursement, you may find it appropriate to file a request for an amended cost report. The Centers for Medicare & Medicaid Services (CMS) Medicare Publication 15-1, Chapter 29, section 2931.2 allows the Medicare administrative contractor (MAC) to accept an amended cost report under limited circumstances, specifically:

1. Correct material errors detected subsequent to filing the original cost report,
2. Comply with health insurance policies or regulations, or
3. Reflect the settlement of a contested liability.

An amended cost report is one which is intended to revise information submitted on a cost report which had been previously filed by the provider. An amended cost report cannot be filed to avail yourself of a cost reporting election that could have been made prior to submitting your report. For example, you may not amend a cost report to modify the allocation methodology used for step-down on worksheet B-1.

To file an amended cost report, please do the following:

• Submit a cover letter to First Coast Service Options Inc. (First Coast), with the cost report fiscal year end that indicates what items were originally submitted on the as-filed cost report, what you are changing, and the reason for the change.
• With each issue, provide as much supporting documentation as necessary to justify each change as well as the Medicare reimbursement effect for each issue.

    • If you are amending a hospital, end-stage renal disease, community mental health center, federally qualified health center, or rural health cost report, you must submit a new disk with the electronic cost report changes incorporated along with a signed and encrypted signature page. We recommend using a color other than black for your original signature to avoid any confusion regarding original signatures versus photocopies.

Once the amended cost report is received in our office, we will review it for acceptability and determine if it is a valid and acceptable amended report. If we deny a portion of your request, you can decide to refile for the issues not in dispute.

http://medicare.fcso.com/PARD_cost_reports/230599.asp

Hospital and ASC Outpatient Quality Reporting (OQR) Program

Hospital Outpatient Quality Reporting (OQR) Program

CMS will impose a two percent reduction to unadjusted-national OPPS rates and the minimum unadjusted and national unadjusted applicable payment rates for the full calendar year (CY) 2015 for hospitals that failed to meet the OQR reporting requirements. For the CY 2017 payment determination, CMS is not proposing new requirements for chart-abstracted data submission, but is adding an additional claims-based measure for colonoscopy. CMS is also proposing a four-month period for review and corrections of chart-abstracted data for the OQR Program following the close of the quarterly reporting period.

Ambulatory Surgery Center Quality Reporting (ASCQR) Program

As with the OQR Program, CMS proposes adding a Medicare Fee for Service claims-based colonoscopy measure to the ASCQR Program for the CY 2017 payment determination and subsequent years. CMS also will continue to apply a 2.0 percentage point reduction to the annual update for ASCs that failure to meet the reporting requirements of the ASCQR Program.
Click on the link, below:

Recovery Audit Program Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals

Guidance on Hospital Inpatient Admission Decisions

Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals

Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities - No Documentation or Insufficient Documentation Submitted

Incorrect Number of Units Billed for Rituximab (HCPCS J9310) and Bevacizumab (HCPCS C9257 and J9035) – Dose versus Units Billed

Probe and Educate Review of the Claims that fall into the 2 midnight rule which are one day stays, excluded are AMA, Death and Transfers and Inpt only procedures

Device Credits change in coding (MODIFIERS)

Billing for Stereotactic Radiosurgery Planning and Delivery

National Coverage Determination NCD for Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers Implementation on 7/7/14 and Effective date 8/13/14

New rule implementation of uniform use of claim adjustment reason codes and remittance advice remark codes
Effective date September 2, 2014

Summary
The Centers for Medicare & Medicaid Services (CMS) released instructions for Medicare administrative contractors to implement the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) rule.

Medicare providers who use Medicare's PC Print or Medicare Remit Easy Print (MREP) software will need to obtain the new version scheduled to be released October 6, 2014. MLN Matters® article MM8711.

WHAT ARE THE RISKS?

Clinical Research Billing errors usually occur because communication has broken down. Some part of the research enterprise has not communicated to another part.

For example, if a hospital billing office does not know that a patient is enrolled as a subject in a research study, then there would be no reason for the billing office to do anything differently with the charges for that patient. Likewise, if a School has taken money for a protocol required service and does not communicate that to the hospital or physician practice, then the hospital billing office would likely bill patients or the patient’s insurer for that service and the physician practice would also likely bill for the physician’s professional fees.

Risk No. 1 – Billing for Services That are Paid for by the Sponsors

When a research site takes money for a clinical service from the sponsor, that service cannot be billed to the patient or the patient’s insurer. If it is billed, then it could be viewed as a “double billing” situation. Double billing occurs when the same service is paid for by two different sources.

In order to manage this risk, the research site must understand what the sponsor is paying for. The budget should be clear as to what is or is not covered by the sponsor’s payment. Likewise, if the study is funded by a grant, there should be a document or an internal budget which clearly identifies what the grant is or is not paying for.

Sites should also realize that the legal portions of the clinical trial agreement can be just as important as the budget exhibit. Usually the “budget” is an exhibit to the clinical trial agreement, which makes the budget and the clinical trial agreement all one legal document. What might look like two documents is in reality one, and must be read and interpreted as one document.

Risk No. 2 - Billing for Services Promised Free in the Informed Consent

Every research informed consent form must identify any “added costs” for the subject if he or she enrolls in the study. Sometimes this part of the informed consent form lists items and services that will not be charged to the patient or the patient’s insurer.

All parts of the research enterprise must live up to the promises in the financial discussion of the informed consent form. If the informed consent states that no services required by the study will be charged to the patient or the patient’s insurance, then that is a promise which must be kept.

It is important to keep in mind that the informed consent form is interpreted from the perspective of the subject and not from the perspective of the investigator or study team.

Clinical research billing (CRB) continues to present challenges to health care providers. Getting it “right” requires coordination of study information among people who may never have worked with each other before. The key to compliant clinical research billing is exchange of information. The more the parts of a research enterprise can communicate with each, the better chance the organization has to safeguard the accuracy of the claims.

One of the first questions an organization needs to tackle in its CRB initiative is to understand what clinical research billing entails and who it involves.

CRB compliance involves any charge for a service that could be directed to a third-party payor. Even small services, such as blood draws, could be charged erroneously. Many parts of a research enterprise may not understand how charges are captured. Understanding the charge capture system is an important first step. CRB also involves correctly charging the study funds or sponsor. The same charges that could go to a third-party payor could also be erroneously charged to the study.
CMS proposes changes to Sunshine Act Reporting

Drug and device manufacturers breathing a sigh of relief after completing their 2013 data submissions under the Physician Payment Sunshine Act (the “Sunshine Act’) must now contend with four proposed changes to the Sunshine Act regulations. On July 3, 2014 the Centers for Medicare & Medicaid Services (“CMS”) released its proposed rule on the 2015 Medicare Physician Fee Schedule (the “Proposed Rule”). The Proposed Rule includes four proposed changes to the Sunshine Act’s reporting requirements based on feedback and experience from the first annual reporting period (covering August 1, 2013 to December 31, 2013). If finalized, these four proposed changes would become effective on January 1, 2015 and would not apply to 2014 reports.

First, the Proposed Rule would eliminate the current exclusion for reporting payments or transfers of value made as compensation for speaking at accredited CME programs. 42 C.F.R. § 403.904(g). Currently, these speaking fees do not have to be reported, so long as the CME program is accredited by one of an enumerated list of accrediting bodies, the manufacturer does not pay the speaker directly, and the manufacturer neither selects the speaker nor provides the event sponsor with a distinct set of speakers from which to choose. Notably, CMS states in the Proposed Rule that it believes that the current regulation exempting CME speaker fees from reporting duplicates the general reporting exclusion for payments or transfers of value where the manufacturer is unaware of the identity of the covered recipient.

In its commentary to the Proposed Rule, CMS states that if the manufacturer provides funding to a CME provider but does not directly select or pay the speaker and does not provide a distinct list of speakers to the CME provider, these indirect payments would be excluded under the general exclusion for payments where the manufacturer is unaware of the recipient’s identity.

Interestingly, CMS does not limit this interpretation to accredited CME events. In addition to its proposal to eliminate 42 C.F.R. § 403.904(g) entirely, CMS is seeking comment on two additional proposals to modify 42 C.F.R. § 403.904(g): (1) expanding the list of accredited CME providers and (2) setting accreditation standards that a CME provider must meet in order for speaker fees to be excluded from reporting.

Second, the Proposed Rule would require manufacturers of devices and medical supplies to report the marketed name for devices or medical supplies related to a particular payment or transfer of value. Currently, the regulations permit a device or medical supply manufacturer to report either the marketed name of the product, the product category, or the therapeutic area, while requiring manufacturers of drugs and biologics to report marketed names.

Third, the Proposed Rule suggests a change to the four “forms of payment” categories under 42 C.F.R. § 403.904(d). Currently, the four categories are (1) cash or cash equivalent, (2) in-kind items or services, (3) stock, stock option, or any other ownership interest, and (4) dividend, profit or other return on investment. The Proposed Rule would divide the third category into three distinct categories: stock, stock option, or any other ownership interest.

Finally, the Proposed Rule would eliminate the definition of “covered device” from 42 C.F.R. § 403.902 as duplicative of the broader definition of “covered drug, device, biological, or medical supply.”

The Proposed Rule is scheduled to be published in the Federal Register on Friday, July 11, 2014, and comments on the Proposed Rule are due by September 2, 2014.
For more resources, you may visit the Office of Billing Compliance Web Page at www.obc.med.miami.edu
If you have any questions on Coding, Billing and Documentation or compliance concerns you may call our office at 305-243-5842
Email address: officeofbillingcompliance@med.miami.edu
or call Toll Free 1-877-415-HELP(4357).
Calls may remain anonymous.

Our On-line Billing Compliance Educational Program by accessing the Ulearn website at: www.Ulearn.miami.edu.

Coding, Billing and Documentation Training Modules (CBLs) available of the Professional Component:
• Billing Compliance Training Fraud Waste and Abuse
• Critical Care Services
• Evaluation and Management (E&M) Services Module I
• Evaluation and Management (E&M) Services Module II
• Major Surgery Global Fee and Minor Surgery Rules
• Medicare Rule for Teaching Physicians
• Psychiatry Services
• Routine Costs in Clinical Trials Billing Guidelines
• Diagnostic Tests Billing Guidelines

For Residents, Fellows and other non-UM employees the links to the CBLs are as follows:
• http://ppto.miami.edu/external/compliance/CriticalCareServiceWeb/index.html
• http://ppto.miami.edu/external/compliance/EMServices_Module1Web/index.html
• http://ppto.miami.edu/external/compliance/EMServices_Module2Web/index.html
• http://ppto.miami.edu/external/compliance/MajorSurgeryGlobalFeeWeb/index.html
• http://ppto.miami.edu/external/compliance/MedicareRuleWeb/index.html
• http://ppto.miami.edu/external/compliance/PsychiatryWeb/index.html
• http://ppto.miami.edu/external/Compliance/ClinicalTrialsBillingGuidelines/index.html

HOSPITAL COMPLIANCE TRAINING MODULES (CBLS)
• Hospital Compliance Orientation
• Billing Compliance Training
• Observation Billing & Documentation Guidelines
• Facility Fee – Clinic Visits Billing & Documentation Guidelines
• An Important Message from Medicare
• Inpatient Hospital Services
• Advanced Beneficiary Notice (ABN)
February 25, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Medicine: Gastroenterology

February 25, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Medicine: Cardiology

February 26, 2014 from 7am to 8am at the JMH West Wing 279 Auditorium — Interventional Radiology

February 26, 2014 from 9:15am to 10:15am at the Highland Professional Building, Classroom 418 — Family Medicine

February 26, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — General Medicine and all Other Specialties

March 5, 2014 from 12pm to 1pm at SCCC 1537 — Radiation/Oncology

March 6, 2014 from 7am to 8am at CRB 989 — Otolaryngology

March 6, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Ortho/Rehab

March 7, 2014 from 7am to 8am at the JMH West Wing 279 Auditorium — Interventional Radiology

March 7, 2014 from 12pm to 1pm at CRB 989 — UMHC Primary Care

March 7, 2014 from 4pm to 5pm at CRB 989 — Neurology

March 17, 2014 from 7am to 8am at the JMH West Wing 279 Auditorium — Diagnostic Radiology

March 17, 2014 from 12pm to 1pm at the Mailman Center 8th Floor Auditorium — Pediatrics

March 17, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Rehab Medicine

March 18, 2014 from 1pm to 2pm at BPEI Stanley H. Arkin Boardroom — Ophthalmology

March 18, 2014 from 8am to 9am at SCCC 1537 — Radiation/Oncology

March 5, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Medicine: Hematology/Oncology

March 19, 2014 from 7am to 8am at the JMH West Wing 279 Auditorium — Diagnostic Radiology

March 19, 2014 from 12pm to 1pm at the Mailman Center 8th Floor Auditorium — Pediatrics

April 14, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Urology

April 14, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — Radiology

April 14, 2014 from 3pm to 4pm at the Mailman Center 8th Floor Auditorium — Surgery

April 15, 2014 from 8:30am to 9:30am at the Mailman Center 8th Floor Auditorium — Psychiatry

April 15, 2014 from 4pm to 5pm at the Mailman Center 8th Floor Auditorium — Surgery

April 28, 2014 from 12pm to 1pm at the Holtz Large Conference Room 2034 — Pathology

April 28, 2014 from 4pm to 5pm at the Mailman Center 8th Floor Auditorium — Surgery

April 29, 2014 from 7am to 8am at the Mailman Center 8th Floor Auditorium — General Medicine

April 29, 2014 from 12pm to 1pm at the Mailman Center 8th Floor Auditorium — Pediatrics

April 29, 2014 from 4pm to 5pm at the Mailman Center 8th Floor Auditorium — Genetics

April 30, 2014 from 7am to 8am at CRB 1179 Conference Room — OBGYN

April 30, 2014 from 12am to 1pm at BPEI 2nd FL Jose Berrocal Auditorium Retter Educational Center — Anesthesiology

April 30, 2014 from 5pm to 6pm at the Mailman Center 8th Floor Auditorium — Ortho/Rehab

May 28, 2014 from 10:30am to 11:30am at RMSB 2090 Library — Dermatology

May 28, 2014 from 2:00pm to 3:00pm at RMSB 2090 Library — Dermatology

May 29, 2014 from 12:15pm to 1:30pm at CRB 1080 Conference Room - Neurology Resident In-Service

July 9, 2014 from 5pm to 7pm BPEI 2nd FL Jose Berrocal Auditorium Retter Educational Center — Ophthalmology

August 28, 2014 from 6:45am to 7:45am at RMSB 3rd FL Auditorium — Anesthesiology

August 28, 2014 from 8:00am to 9:00am at Lois Pope Life Center 7th FL Auditorium — Neurosurgery
Office of Billing Compliance

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