Office of Billing Compliance
2014 Professional Coding, Billing and Documentation Program

OB / GYN

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What is a Compliance Program?

7 Elements of an Effective Compliance Program

- A centralized process to promote honest, ethical behavior in the day-to-day operations of an organization, which will allow the organization to identify, correct, and prevent illegal conduct.
- It is a system of: FIND – FIX – PREVENT

The University of Miami implemented the Billing Compliance Plan on November 12, 1996. The components of the Compliance Plan are:

1. Policies and Procedures
2. Having a Compliance Officer and Compliance Committees
3. Effective Training and Education
4. Effective Lines of Communication (1-877-415-4357 or 305-243-5842)
5. Disciplinary Guidelines
6. Auditing and Monitoring
7. Detect Non-Compliance Issues and Develop Corrective Action Plans
The Government

• In order to address fraud and abuse in the Healthcare Field, the government has on-going reviews and investigations nationally to detect any actual or perceived waste and abuse.

• The Government does believe that the majority of Healthcare providers deliver quality care and submit accurate claims. However, the amount of money in the healthcare system, makes it a prime target for fraud and abuse.

Centers for Medicare and Medicaid Services (CMS) Estimates > $50 Billion In “Payment Errors” Annually in Healthcare

OIG reported that in FY 2013 that $5.8 billion was recovered from auditing providers
Health Care Laws

There are five important health care laws that have a significant impact on how we conduct business:

- False Claims Act
- Health Care Fraud Statute
- Anti-Kickback Statute
- Stark Law
- Sunshine Act
  
  Requires manufacturers of drugs, medical devices and biologicals that participate in U.S. federal health care programs to report certain payments and items of value >$10 given to physicians and teaching hospitals.
What is a False Claim?

- A false claim is the knowing submission of a false or fraudulent claim for payment or approval or the use of a false record that is material to a false claim.

OR

- Reckless disregard of the truth or an attempt to remain ignorant of billing requirements are also considered violations of the False Claims Act.
How do you create a False Claim?

One method is to submit a claim form to the government.

This certification forms the basis for a false claim.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)
MEDICAL NECESSITY

Quality & Cost:
Emphasis on Pay-for-Performance
Practitioner reimbursement will likely be tied to outcomes soon.

Some experts say that the CMS penalties for not participating in the Physician Quality Reporting System (PQRS) signal that the pay-for-performance trend is not fading away and will likely be adopted by private payers.

“I think we’re slowly transitioning out of fee-for-service and into a system that rewards for quality while controlling cost,” says Miranda Franco, government affairs representative for the Medical Group Management Association. “The intent of CMS is to have physicians moving toward capturing quality data and improving metrics on [them].”
Medical Necessity
Elective Procedures Alert

When applicable for all prior procedures should be documented:

- List all failed:
  - Therapies in the patients history or operative report
  - Medication trials
  - Prior surgeries, interventions or procedures

Document worsening conditions as evidenced by abnormal test results or decline in functional abilities or why this elective procedure is the best option for the patient if other, lower cost options are available.

Criteria which establishes medical necessity guidelines have been established for many procedures and diagnostic studies.

**DOCUMENT!** **DOCUMENT!**
Audits are being conducted for all payer types based on the medical necessity of procedures and E/M levels. Procedure are often linked to diagnosis codes and the E/M audits are generally expressed in two ways in conjunction with the needs of the patient:

- Frequency of services (how often the patients are being seen) and,
- Intensity of service (level of CPT code billed).
Elements of Medical Necessity

- CMS’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.

- Complexity of documented co-morbidities that clearly influenced physician work.

- Physical scope encompassed by the problems (number of physical systems affected by the problems).
E/M Coding: Volume of Documentation versus Medical Necessity

• Word processing software, the electronic medical record, and formatted note systems facilitate the "carry over" and repetitive "fill in" of stored information.

• Even if a "complete" note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service.

• Information that has no pertinence to the patient's situation at that specific time cannot be counted.

An ISO 9001:2008 certified company
Office of the Inspector General (OIG) Audit Focus

Annually OIG publishes it "targets" for the upcoming year. Included is:

- **Cutting and Pasting Documentation in the EMR**

  REMEMBER: More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the service provided on the DOS.
Pre EMR: “If it isn’t documented, it hasn’t been done.”

- Unknown

Post EMR: “If it was documented, was it done and was it medically necessary to do.”

- Reviewers
EMR Documentation Pitfalls

- On reviews, the following are targets to call into question EMR documentation is original and accurate:
  - HPI and ROS don’t agree
  - HPI and PE don’t agree
  - CC is not addressed in the PE
  - ROS and PFSH complete on every visit
  - ROS all negative when patient coming for a CC
  - Identical documentation across services (cloning)
  - The lack of or Inappropriate Teaching Physician Attestations
Evaluation and Management E/M

Documentation and Coding

Inpatient, Outpatient and Consultations
What is the definition of "new patient" for billing E/M services?

- “New patient" is a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years.

- An interpretation of a diagnostic test, reading an x-ray or EKG etc., (billed with a -26 modifier ) in the absence of an E/M service or other face-to-face service with the patient, that does not affect the designation of a new patient.
E/M Key Components

History (HX)- Subjective information
Examination (PE)- Objective information
Medical Decision Making (MDM)- Linked to medical necessity

The billable service is determined by the combination of these 3 key components with MDM often linked to medical necessity. For new patients all 3 components must be met or exceeded and established patient visits 2 of 3 are required to be met or exceeded. Often when downcoded for medical necessity it is determined that documented History and Exam exceeded what was necessary for the visit.
Elements of an E/M History

- The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem. Documentation of the patient’s history includes some or all of the following elements:

  - Chief Complaint (CC) & History of Present Illness (HPI)
  - Why is the patient being seen today
  - Review of Systems (ROS),
  - Past Family, Social History (PFSH).
History of Present Illness (HPI)
A KEY to Support Medical Necessity to in addition to MDM

- HPI is chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present or the status of chronic conditions being treated at this visit.
  - The HPI must be performed and documented by the billing provider for New Patients in order to be counted towards the New Patient level of service billed.

- Focus upon present illness!

- HPI drivers:
  - Extent of PFSH, ROS and physical exam performed
  - Medical necessity for amount work performed and documented & Medical necessity for E & M assignment
HPI

• Status of chronic conditions being managed at visit
  • Just listing the chronic conditions is a medical history
  • Their status must be addressed for HPI coding

OR

• Documentation of the HPI applicable elements relative to the diagnosis or signs/symptoms being managed at visit
  • Location
  • Quality
  • Severity
  • Duration
  • Timing
  • Context
  • Modifying factors
  • Associated signs and symptoms
Review of Systems (ROS)

- 1 ROS documented = Pertinent

- 2-9 ROS documented = Extended

- 10 + = Complete (or documentation of pertinent positive and negative ROS and a notation “all others negative”. This would indicate all 14 ROS were performed and would be complete.)

Record positives and pertinent negatives. Never note the system(s) related to the presenting problem as "negative". When using "negative" notation, always identify which systems were queried and found to be negative.
Review of Systems

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic
- All Others Negative
Past, Family, and/or Social History

- **Past history**: the patient’s past experience with illnesses, surgeries, & treatments
- **Family history**: a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk
- **Social history**: age appropriate review of past and current activities

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services.

Don't use the term "non-contributory"
### Scoring E/M History

#### CHIEF COMPLAINT:

**HPI (history of present illness) elements:** (Extended also includes status of 3 or > chronic conditions)

<table>
<thead>
<tr>
<th>Location</th>
<th>Severity</th>
<th>Timing</th>
<th>Modifying Factors</th>
<th>Brief (1-3)</th>
<th>Extended 4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Duration</td>
<td>Context</td>
<td>Associated signs and symptoms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ROS (Review of systems):

- **Constitutional (wt loss, etc)**
- Ears, nose, mouth, throat
- GI
- Integumentary (skin, breast)
- Endo

<table>
<thead>
<tr>
<th>Eyes</th>
<th>Card/vasc</th>
<th>GU</th>
<th>Neuro</th>
<th>Hem/Lymph</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resp</td>
<td>MS</td>
<td>Psych</td>
<td>All/immuno</td>
<td>All others negative</td>
</tr>
</tbody>
</table>

#### PFSH (past medical, family, social history) areas:

- **Past history** (the patient’s past experiences with illness, operations, injuries and treatments)
- **Family history** (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- **Social history** (an age appropriate review of past and current activities)

* Complete PFSH:

**10 or more systems, or some systems with statement all others neg.**

2 hx areas: a) Estab pts. Office (outpt) care; domiciliary care; home care
b) Emergency dept c) Subsequent nursing facility

3 hx areas: a) New pts. Office (outpt) care; domiciliary care; home care
b) Consultations c) Initial hospital care d) Hospital observation
e) Comprehensive nursing facility assessments

**PROBLEM FOCUSED (PF)**  **EXP. PROB. FOCUSED (EPF)**  **DETAILED (D)**  **COMPREHENSIVE (C)**
EXAMINATION

- 4 TYPES OF EXAMS
  - Problem focused (PF)
  - Expanded problem focused (EPF)
  - Detailed (D)
  - Comprehensive (C)
### Coding 1995: Physical Exam Definitions

**BODY AREAS (BA):**
- Head, including face
- Neck
- Chest, including breast and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

**CODING ORGAN SYSTEMS (OS):**
- Constitutional/General
- Eyes
- Ears/Nose/Mouth/Throat
- Respiratory
- Cardiac
- GI
- GU
- Musculoskeletal
- Skin
- Neuro
- Psychiatric
- Hematologic/Lymphatic
1997 Sub-Specialty Physical Exam

- Cardiovascular
- Musculoskeletal
- Ears, Nose, Mouth and Throat
- Neurological
- Eyes
- Skin
- Psychiatric
- Genitourinary (Female) (Male)
- Respiratory
- Hematologic/Lymphatic/Immunologic
- General Multi-system Exam
### GU Examination

**Constitutional**
- Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient e.g., development, nutrition, body habitus, deformities, attention to grooming

**Neck**
- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (e.g., enlargement, tenderness, mass)
- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
- Auscultation of heart with notation of abnormal sounds and murmurs

**Respiratory**
- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
- Auscultation of heart with notation of abnormal sounds and murmurs

**Cardiovascular**
- Auscultation of heart with notation of abnormal sounds and murmurs

**Gastrointestinal**
- Examination of abdomen with notation of presence of masses or tenderness
- Examination for presence or absence of hernia
- Examination of liver and spleen
- Obtain stool sample for occult blood test when indicated

**FEMALE:**
- Includes **at least seven of the following eleven** elements identified by bullets:
  - Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge)
  - Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses

**Pelvic examination (with or without specimen collection for smears and cultures) including:**
- External genitalia (e.g., general appearance, hair distribution, lesions)
- Urethral meatus (e.g., size, location, lesions, prolapse)
- Urethra (e.g., masses, tenderness, scarring)
- Bladder (e.g., fullness, masses, tenderness)
- Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
- Cervix (e.g., general appearance, lesions, discharge)
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
- Anus and perineum
1995 and 1997 Exam Definitions

Problem Focused (PF)

- ’95: a limited exam of the affected body area or organ system. (1 BA/OS)
- ’97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF)

- ’95: a limited exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- ’97=Specialty and GMS: At least 6 elements identified by bullet.

Detailed (D)

- ’95: extended exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- ’97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc) GNS= At least 2 bullets from each of 6 areas or at least 12 in 2 or more areas.

Comprehensive (C)

- ’95: general multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- ’97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area. GMS: At least 2 elements with bullet from each of 9 areas/systems.
Medical Decision Making

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE!!

Exchange of clinically reasonable and necessary information and the use of this information in the clinical management of the patient

**Step 1:**
- Number of possible diagnosis and/or the number of management options.

**Step 2:**
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.

**Step 3:**
- The risk of significant complications, morbidity, and/or mortality with the patient’s problem(s), diagnostic procedure(s), and/or possible management options.

Note: The 2 most complex elements out of 3 will determine the overall level of MDM.
3. MEDICAL DECISION MAKING

A) Number of Diagnosis or Treatment Options - identify each

<table>
<thead>
<tr>
<th>Problem(s) Status</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max=2</td>
<td>1</td>
<td>1 POINT: E- 2, NEW-1,2</td>
</tr>
<tr>
<td>Est. Problem (to examiner) stable, improved</td>
<td></td>
<td>1</td>
<td>2 POINTS: E-3, NEW-3</td>
</tr>
<tr>
<td>Est. Problem (to examiner) worsening</td>
<td></td>
<td>2</td>
<td>3 POINTS: E-4, NEW-4</td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max=1</td>
<td>3</td>
<td>4 POINTS: E-5, NEW-5</td>
</tr>
<tr>
<td>New prob. (To examiner); additional workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total: 1 POINT: E- 2, NEW-1,2
2 POINTS: E-3, NEW-3
3 POINTS: E-4, NEW-4
4 POINTS: E-5, NEW-5
### Amount and/or Complexity of Data Reviewed - total the points

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests.</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT.</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT.</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician.</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient.</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider.</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report).</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total**
MDM Step 3: Table of Risk

- The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.
  - DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

- Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention.
Risk Table

- Assess Patient Risk Based On:
  - Diagnoses
  - Diagnostics
  - Management Options

- Risk is assessed based on the risk to the patient between present visit and the NEXT time the patient will be seen by billing provider or risk for planned intervention
Risk of Complications and/or Morbidity or Mortality
Risk related to the Presenting Problem is based on the risk anticipated between the current and next encounter. Risk related to Diagnostic Procedures or Management Options is based on the risk anticipated during and immediately after procedure or txt.

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table Below).

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>• One self-limited or minor problem e.g., cold, insect bite</td>
<td>• Laboratory tests requiring venipuncture&lt;br&gt;• Chest x-rays&lt;br&gt;• EKG/EEG&lt;br&gt;• Urinalysis&lt;br&gt;• Ultrasound&lt;br&gt;• KOH prep</td>
<td>• Rest&lt;br&gt;• Gargles&lt;br&gt;• Elastic bandages&lt;br&gt;• Superficial dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>• Two or more self-limited or minor problems&lt;br&gt;• One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes&lt;br&gt;• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>• Physiologic tests not under stress, e.g., pulmonary function tests&lt;br&gt;• Non-cardiovascular imaging studies with contrast, e.g., barium enema&lt;br&gt;• Superficial needle biopsies&lt;br&gt;• Clinical laboratory tests requiring arterial puncture&lt;br&gt;• Skin biopsies</td>
<td>• Over-the-counter drugs&lt;br&gt;• Minor surgery with no identified risk factors&lt;br&gt;• Physical therapy&lt;br&gt;• Occupational therapy&lt;br&gt;• IV Fluids without additives</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment&lt;br&gt;• Two or more stable chronic illnesses&lt;br&gt;• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast&lt;br&gt;• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis&lt;br&gt;• Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>• Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction test&lt;br&gt;• Diagnostic endoscopies with no identified risk factors&lt;br&gt;• Deep needle or incisional biopsy&lt;br&gt;• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath&lt;br&gt;• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Minor surgery with identified risk factors&lt;br&gt;• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors&lt;br&gt;• Prescription drug management&lt;br&gt;• Therapeutic nuclear medicine&lt;br&gt;• IV fluids with additives&lt;br&gt;• Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment&lt;br&gt;• Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure&lt;br&gt;• An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors&lt;br&gt;• Cardiac electrophysiological tests&lt;br&gt;• Diagnostic endoscopies with identified risk factors&lt;br&gt;• Discography</td>
<td>• Elective major surgery (open, percutaneous or endoscopic with identified risk factors)&lt;br&gt;• Emergency major surgery (open, percutaneous or endoscopic with identified risk factors)&lt;br&gt;• Parenteral controlled substances&lt;br&gt;• Drug therapy requiring intensive monitoring for toxicity&lt;br&gt;• Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2\textsuperscript{nd} circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid.

### Final Result for Complexity

<table>
<thead>
<tr>
<th></th>
<th>A: Number diagnoses or treatment options</th>
<th>B: Highest Risk</th>
<th>C: Amount and complexity of data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \leq 1 ) Minimal</td>
<td>Minimal</td>
<td>( \leq 1 ) Minimal or low</td>
</tr>
<tr>
<td></td>
<td>2 Limited</td>
<td>Low</td>
<td>2 Limited</td>
</tr>
<tr>
<td></td>
<td>3 Multiple</td>
<td>Moderate</td>
<td>3 Multiple</td>
</tr>
<tr>
<td></td>
<td>( \geq 4 ) Extensive</td>
<td>High</td>
<td>( \geq 4 ) Extensive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>STRAIGHT-FORWARD</td>
</tr>
<tr>
<td></td>
<td>LOW COMPLEX</td>
</tr>
<tr>
<td></td>
<td>MODERATE COMPLEX</td>
</tr>
<tr>
<td></td>
<td>HIGH COMPLEX</td>
</tr>
</tbody>
</table>
Using Time to Code

Time shall be considered for coding an E/M level when greater than 50% of total Teaching Physician visit time is Counseling /Coordinating Care –

Total time must be Face-to-face for OP and floor time / face-to-face for IP
What Is Counseling / Coordinating Care (CCC)?

A Discussion of:

- Diagnostic results, impressions, and/or recommended studies
- Prognosis
- Risks and benefits of management
- Instructions for treatment and/or follow-up
- Importance of compliance

Required Documentation:

- Total time of the encounter
- The amount of time dedicated to counseling / coordination of care
- The nature of counseling/coordination of care
The NP or PA MUST BE AN EMPLOYEE OF THE PRACTICE AND CANNOT BE A HOSPITAL EMPLOYEE TO UTILIZE ANY OF THEIR DOCUMENTATION FOR PHYSICIAN BILLING AS SHARED

- Shared visit with an NPP may be billed under the physician's name only if:
  - The physician provides a face-to-face portion of the visit and
  - The physician personally documents in the patient's record the portion of the E/M encounter with the patient they provided.

- If the physician does not personally perform or personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter may only be billed under the PA/ARNP's name and provider number.

- Procedures must be billed under the performing provider & not the supervisor. They cannot be “shared”
National ‘12 CMS Data For Speciality E/M

Obstetrics/Gynecology

- 99211: 2%
- 99212: 13%
- 99213: 49%
- 99214: 30%
- 99215: 6%
# Top Procedure Codes Billed OB-GYN

## Top 5 CPT Families by Units (Excl. E&M)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>% Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>76816</td>
<td>US, PREGNANT UTERUS, F/U, TRANSABD APP</td>
<td>8%</td>
</tr>
<tr>
<td>76830</td>
<td>ECHOGRAPHY, TRANSVAGINAL</td>
<td>7%</td>
</tr>
<tr>
<td>76856</td>
<td>US, PELVIC (NONOBSTETRIC), REAL TIME, COMPLETE</td>
<td>7%</td>
</tr>
<tr>
<td>76819</td>
<td>FETAL BIOPHYS PROF, W/O NST</td>
<td>6%</td>
</tr>
<tr>
<td>76817</td>
<td>US, PREGNANT UTERUS, TRANSVAGINAL</td>
<td>6%</td>
</tr>
<tr>
<td>All Other Codes</td>
<td></td>
<td>65%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100.00%</td>
</tr>
</tbody>
</table>

## Top 5 E&M by Units

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>% Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>OFFICE/OUTPT VISIT, EST, LEVL III</td>
<td>23%</td>
</tr>
<tr>
<td>99396</td>
<td>PREVENTIVE VISIT, EST, 40-64</td>
<td>13%</td>
</tr>
<tr>
<td>99214</td>
<td>OFFICE/OUTPT VISIT, EST, LEVL IV</td>
<td>13%</td>
</tr>
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<td>99232</td>
<td>SUBSEQUENT HOSPITAL CARE, LEVL II</td>
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</tr>
<tr>
<td>99395</td>
<td>PREVENTIVE VISIT, EST, 18-39</td>
<td>8%</td>
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<tr>
<td>All Other Codes</td>
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<td>33%</td>
</tr>
<tr>
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<td></td>
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Routine Physical Exam: Preventive

- Periodic comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, coded as new or established patient; infant to 65 years & older.
Preventive Medicine Services 99381-99395:
Asymptomatic Routine Physical

The extent and focus of the services will largely depend on the age of the patient. Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination.

The "comprehensive" nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is not synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing preventive services, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate code should also be reported with Modifier 25.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine service and which does not require significant additional work and the performance of the key components of a problem-oriented E/M service should not be reported.
Billing for Well Woman Exams for Medicare Patients
Medicare will reimburse for G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and Q0091 (Pap Smear) if it has been 2 years since the patient has had these services or annually if the patient meets the criteria for high-risk.

Source: Noridian Medicare Services
Q0091 (Pap Smear) - A screening Pap smear and pelvic examination (including clinical breast examination) are covered by Medicare every 2 years for every female beneficiary (e.g., none paid by Medicare during the preceding 23 months following the month in which her last Medicare-covered screening pelvic examination was performed and found to be normal).

Use ICD-9-CM diagnosis code V76.2, V72.31, V76.47 or V76.49 to indicate low risk.

Source: Noridian Medicare Services
High risk factors for cervical and vaginal cancer are any one of the following:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (five or more in a lifetime);
- History of sexually transmitted disease (including human immunodeficiency virus {HIV});
- Fewer than three negative Pap smears within the previous 7 years;
- Prenatal exposure to diethylstilbestrol – Exposed daughters of women who took DES during pregnancy.
Screening Breast & Pelvic Exam: G0101

- In order to bill screening breast and pelvic exam, documentation MUST include at least seven of the following eleven elements:
  1. Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge)
  2. Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses

Covered once every 2 years. Annually if high risk for cervical or vaginal cancer, or if the patient is of childbearing age and has had an abnormal Pap smear in the preceding 3 years. Can also bill a Screening Pap Smear: G0123-G0148 – and Q0091 – Collection of Pap Smear
Covered once every 2 years. Annually if high risk for cervical or vaginal cancer, or if the patient is of childbearing age and has had an abnormal Pap smear in the preceding 3 years
Screening Breast & Pelvic: G0101 (con't)

- Pelvic examination (with or without specimen collection for smears and cultures) including:
  3. External genitalia (e.g., general appearance, hair distribution, lesions)
  4. Urethral meatus (e.g., size, location, lesions, prolapse)
  5. Urethra (e.g., masses, tenderness, scarring)
  6. Bladder (e.g., fullness, masses, tenderness)
  7. Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
  8. Cervix (e.g., general appearance, lesions, discharge)
  9. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
 10. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)
 11. Anus and perineum
PAP and Documentation for > 11

- **PREVENTIVE MEDICINE or EM SERVICE PROVIDED AT THE TIME OF COVERED SCREENING SERVICE**
  - A preventive medicine exam includes a comprehensive age and gender appropriate history, examination, counseling/anticipatory guidance/risk-factor reduction interventions, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures.
  - Sometimes these other elements are performed during the same visit as the Medicare covered services, particularly G0101 and Q0091.
  - These services or a medically necessary E/M service can be billed in addition to the preventive services.
Routine physical examinations or preventive medicine services (99381 – 99499) furnished in conjunction with a medically necessary visit or covered screening pelvic examination visit: An Advanced Beneficiary Notice (ABN) to the beneficiary is not required because Medicare coverage of routine physical examinations is denied on the basis of statutory exclusion.

Very Important: Documentation must support two distinct services
Medicare Well Woman

ICD-9-CM Diagnosis Codes to be used for Screening Pelvic and Pap Smear (as specified under the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy)

- **V15.89** Other personal history presenting hazards to health
- **V72.31** Routine gynecological examination
- **V76.2** Special screening for malignant neoplasm; cervix
- **V76.47** Special screening for malignant neoplasm; vagina
- **V76.49** Special screening for malignant neoplasm; other sites
Q. Patients often present for a preventive exam and also ask for evaluation and management of specific problems (e.g., heartburn, chest pain). Is it appropriate to submit both a preventive medicine services code with a diagnosis code for a general medical exam and an appropriate office visit code with a diagnosis code for the specific problem?

A. Yes, as long as the documentation supports a separately identifiable E/M with a 25 modifier

In the notes preceding the Preventive Medicine Services codes, CPT states that "if an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine [E/M] service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office/outpatient code 99201-99215 should also be reported."
Billing Preventive and Medicare E/M

- Medicare recognizes this coding convention but does not cover comprehensive preventive examinations.
  - Medicare patient's financial obligation for the non-covered preventive service should be reduced by the physician's current established charge for the office visit when both services are reported, since Medicare considers the services to be two parts of the whole encounter rather than two separate services.
- Medicare also considers screening pelvic exams (G0101, "Cervical or vaginal cancer screening; pelvic and clinical breast examination") and screening digital rectal exams (G0102, "Prostate cancer screening; digital rectal examination") to be potentially covered portions of the encounter, so the patient's bill for the non-covered preventive service should also be reduced by the physician's charges for these screening exams.

Best Documentation practice is 2 distinct notes – even in the EMR.
  - Separately identifiable service is carved-out and leveled for E/M code
Billing for Services of Undocumented Aliens

- Under Title 42, Code of Federal Regulations (CFR) 440.255, states are required to cover emergency medical services for illegal (undocumented) aliens when these persons meet all other Medicaid eligibility requirements. As a result, Florida Medicaid reimburses for emergency services provided to undocumented aliens who meet all Medicaid eligibility requirements, except for citizenship or alien status.

- Inpatient admission for non-qualified, non-citizens who are eligible for Medicaid under the Emergency Medicaid for Aliens category of assistance must be authorized by the Peer Review Organization (PRO), if authorization is required for the type of admission.

- Medicaid coverage of inpatient services for non-qualified, non-citizens is limited to emergencies, newborn delivery services, and dialysis services.
Delivery, Antepartum and Postpartum Care
Billing Ultrasounds

- One ultrasound (procedure code 76801 or 76805) is reimbursed per pregnancy regardless of pregnancy risk factors.
  - Modifier 22 cannot be used with procedure code 76801 or 76805.
- Complex pregnancy conditions may require a detailed fetal anatomic examination. Florida Medicaid will reimburse one ultrasound (procedure code 76811) to provider specialties 47 (radiology) and 65 (maternal/fetal).
  - This procedure is limited to one procedure per pregnancy and must include a detailed anatomic evaluation of fetal brain and ventricles, face, heart with outflow tracts, chest anatomy, abdominal organ specific anatomy, and limbs. As clinically indicated, a detailed evaluation of the umbilical cord, placenta and other fetal anatomy must be documented and maintained in the medical record.
- For multiple gestations, an additional procedure code, 76812, must be included to identify the additional gestation with a detailed fetal anatomic examination.
  - Documentation must include the same components as procedure code 76811, and maintained in the medical records.
Billing Ultrasounds

- Follow-up ultrasounds (procedure code 76815 or 76816) are reimbursed for recipients who have a diagnosis listed on the Diagnosis Code List for Additional Ultrasounds for Pregnant Women (Appendix C).
  - A maximum of three follow-up ultrasounds may be reimbursed with a diagnosis code on Appendix C with no documentation of medical necessity.
- If more than three follow-up ultrasounds are required, the additional ultrasound(s) must be billed with a modifier 22.
  - A report must be submitted with the claim that documents the medical necessity, its findings, and a plan of care. Only the diagnosis or diagnoses justifying the reason or reasons for the follow-up ultrasound should be included on the claim. Supporting documentation must be included for each diagnosis listed on the claim. Without all components of this documentation the claim will be denied.
- Abbreviated ultrasounds (procedure code 76815) are reimbursed for fetal position, fetal heart beat, placenta location or qualitative amniotic fluid volume when clinically indicated.
- Follow-up ultrasounds (procedure code 76816) are reimbursed when findings including fetal measurements for assessment of fetal size, and interval growth or re-evaluation of one or more anatomic abnormalities are documented in the report.

For more information on billing ultrasounds you may refer to the Florida Medicaid Practitioner Coverage and Limitations Handbook Chapter 2 Pages 63-72.
Delivery, Antepartum and Postpartum Care

The CPT has four classifications of delivery Codes

**Vaginal Delivery**

- **59400** - Routine obstetric care including antepartum care, vaginal delivery (w/or w/o episiotomy, and/or forceps) and postpartum care
- **59409** - Vaginal delivery only (with or without episiotomy and/or forceps)
- **59410** - Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care

**Cesarean Delivery**

- **59510** - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- **59514** - Cesarean delivery only
- **59515** - Cesarean delivery only; including postpartum care
**Delivery, Antepartum and Postpartum Care**

**Vaginal Delivery after C-section**

59610 - Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

59612 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)

59611 - Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care

**Failed Vaginal Delivery after C-section**

59618 - Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

59620 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

59622 - Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care
The following services are included in the OB global package:

- The initial obstetrics visit. This includes patient history, examination, recording of weight, vital signs and counseling and/or advise provided regarding the pregnancy.
- Monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits to delivery to monitor ongoing progress of the pregnancy. This includes weight and vital sign monitoring, assessment of fetal heart tones and routine chemical urinalysis.
- Routine fetal monitoring during labor.
- The ordering and administration by the attending physician of medication during labor (i.e., Pitocin).
- Hospital admission and discharge services (labor & delivery). Hospital admission with 24 hours of the delivery is considered part of the OB package and can not be billed separately.
Normal Spontaneous Vaginal Delivery

- Management of uncomplicated labor including fetal monitoring
- Placement of internal fetal and/or uterine monitors
- Vaginal delivery with or without forceps or vacuum extraction
- Delivery of placenta, any method
- Episiotomy and repair/suturing of lacerations
- Administration of intravenous oxytocin
Cesarean Delivery

- Management of uncomplicated labor including fetal monitoring
- Preoperative counseling including rationale for cesarean delivery
- Incision into uterus with delivery of fetus, placenta and fetal membranes
- Placement of internal fetal and/or uterine monitors
- Administration of intravenous oxytocin.
Reporting Multifetal Deliveries

- Both vaginal deliveries report one global obstetrical (with vaginal delivery) code (59400 or 59610) plus a code for vaginal delivery only (59409-51 or 59612-51).
- One vaginal delivery and one cesarean delivery, report one global obstetrical (with cesarean delivery) code (59510 or 59618) plus a code for vaginal delivery only (59409-51 or 59612-51).
- Both cesarean deliveries, report only one global obstetrical (with cesarean delivery) code (59510 or 59618). Only one code is reported since only one cesarean incision was made.

Source: American College of Obstetrics & Gynecology
Billing for Sterilizations for Medicaid

- Sterilizations are reimbursable using the appropriate CPT code, TG modifier, and diagnosis code.
- The waiting period between obtaining the written consent and the sterilization procedure must be at least 30 days but no more than 180 days.
- In cases of a premature delivery, the consent must have been completed and signed at least 30 days prior to the expected date of delivery and 72 hours prior to sterilization.
- Abbreviations and signature stamps are not acceptable on these forms.
- The physician who performed the sterilization must sign and date the Consent for Sterilization form on or after the date the sterilization procedure was performed.
Hysterectomy Acknowledgement Form

- Hysterectomies are reimbursable using the appropriate CPT code, TG modifier, and diagnosis code.
- Federal regulations require that a recipient or her representative be informed verbally and in writing prior to a hysterectomy that the operation will make her permanently incapable of reproducing. Federal regulations further require that the recipient or her representative sign a written acknowledgment of receipt of this information.
- The provider must have either obtained a Hysterectomy Acknowledgment Form, or a consent form that includes the same information as the Hysterectomy Acknowledgment Form in order to be reimbursed by Medicaid. If the provider does not obtain the Form or a consent form that contains the same information, Medicaid cannot reimburse for the service.
- An Exception to Hysterectomy Acknowledgment Form is required if the patient;
  - was sterile before hysterectomy was performed; or
  - required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior completion of the Hysterectomy Acknowledgment Form was not possible.
Regional Perinatal Intensive Care Center (RPICC) Program

Any of the following services provided to a RPICC recipient are reimbursed on a fee-for-service basis using CPT procedure code billing (not covered by RPICC Program):

- Outpatient services
- Medically necessary consultations provided by physicians who are not part of the RPICC group
- Radiology and pathology services provided by physicians who are not part of the RPICC group
- Nurse midwife services including those provided under the direct supervision of the RPICC medical consultant

The above services should be billed using the non-RPICC Medicaid group number.
RPICC Program

- Payment for inpatient professional services is based on CPT codes for obstetrics and neonates as listed on the RPICC Fee Schedule.
- To receive the RPICC reimbursement, all physician care must be directly rendered or directly supervised by the RPICC provider submitting the claim.
- The RPICC payment is a global fee that covers all services or procedures performed by the RPICC provider group.
- Only inpatient professional services may be billed through the RPICC provider group number. All other Medicaid fee-for-service reimbursement must be billed through the non-RPICC provider group number.
- When the recipient is an inpatient, all testing is included in the hospital payment. No testing that is performed outside the facility is reimbursed separately during the recipient's inpatient stay.
RPICC Program

- One all-inclusive fee is paid for a total number of antepartum or postpartum hospital days accumulated during 1 or > hospitalizations.
- When billing multiple antepartum or postpartum hospitalizations for the same recipient, enter the appropriate CPT code with the TG modifier along with a modifier 22 on each claim line for each hospitalization.
  - Include from-through days, length of stay (LOS), usual and customary fee, and submit the RPICC Entitlement Report. The usual and customary charges must be at least equal to the entitlement.
- Deliveries of < than 20 full weeks gestation are reimbursed as an antepartum hospitalization and not a delivery.
- An antepartum hospitalization that progresses to a delivery is reimbursed only as a delivery.
- All claims for antepartum services must have an “F” in the family planning indicator in order to exempt the claim from the recipient copayment.
- Antepartum hospitalization of < than one day is considered an outpatient service and cannot be billed as an Obstetrical Care Group (OBCG).
Guidelines for Teaching Physicians, Interns, Residents and Fellows

For Billing Services, All Types of Services Involving a Teaching Physician (TP) Requires Attestations In EHR or Paper Charts
E/M IP or OP: TP must personally document at least the following:

- That s/he performed the service or was physically present during the key or critical portions of the service when performed by the resident; AND
- The participation of the teaching physician in the management of the patient.

Example: ‘I saw and examined the patient and agree with the resident’s note...’

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
Unacceptable TP Documentation

- Assessed and Agree
- Reviewed and Agree
- Co-signed Note
- Patient seen and examined and I agree with the note
- As documented by resident, I agree with the history, exam and assessment/plan
Procedures

**Minor** – (< 5 Minutes & 0 -10 Day Global): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Example: "I was present for the entire procedure." i.e. Pap

**Major** – (>5 Minutes) (Including C-Section)

- SINGLE Procedure / Surgery — When the teaching surgeon is present or performs the procedure for a single non-overlapping case involving a resident, he/she or the resident can document the TP’s physical presence and participation in the surgery.

  Example: “I was present for the entire (or key and critical portions) of the procedure and immediately available.”

**Deliveries** (Delivery-only codes (59409, 59514, or 59612, 59620) - TP must be present during key portions of each stage of delivery.

- Admission to the hospital (admission H&P)
- Uncomplicated labor and infant delivery
- Delivery of Placenta
**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.**
Modifier Reminders

**Modifier 22:** Services performed are significantly greater than usually required”, therefore its use should be exceptional.

**Modifier 24:** Separately Identifiable E/M by the Same Physician/Group during the global period

**Modifier 25:** Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of a minor Procedure: on the day a procedure the patient's condition required a significant, separately identifiable E/M service above and beyond the usual care associated with the procedure that was performed.

**Modifier 57:** Significant, Separately Identifiable E/M by the Same Physician/Group on the Day of or within 24 hours of a major procedure.

**Modifier 59:** Distinct Procedural Service: Under certain circumstances, indicate that a procedure or service was independent from the services performed on the same day.

**Modifier GC:** Service involved a resident or fellow. Payment not affected.
Modifier Reminders

**Modifier 62:** Co-Surgery - Two surgeons (usually with different skills) with specialized skills act as co-surgeons. Both are primary surgeons, performing distinct parts of a single reportable procedure (same CPT code) performing the parts of the procedure simultaneously, e.g., heart transplant or bilateral knee replacements. (pays 125% of fee schedule)

- Co-surgery may be required because of the complexity of the procedure and/or the patient’s condition
- The additional surgeon is not working as an assistant, but is performing a distinct part of the procedure
- Each surgeon dictates his/her operative note describing his/her involvement in the procedure

**Modifier 82:** Assistant Surgeon in a Teaching Hospital: In general, the services of assistants for surgeries furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service is non-payable. However, it is covered if such services are exceptional medical circumstances. The teaching physician must document in the operative note that a qualified resident was unavailable for the procedure and *Documentation of qualifying circumstances must be included in the operating report.* Medicare would add 16% of the global package. Medicaid – 20%. This modifier is to be reported by the assistant surgeon only not by the primary surgeon.
ICD-10 and Clinical Documentation

- Increased specificity of the ICD-10 codes requires more detailed clinical documentation to code some diagnoses to the highest level of specificity.

- Coding and documentation go hand in hand
  - ICD-10 based on complete and accurate documentation, even where it comes to right and left or episode of care.
  - ICD-10 should impact documentation as physicians are required to support medical necessity using appropriate diagnosis code—this is not an easy situation.

- Will not change the way a physician practices medicine
HIPAA
Final Reminders for All Staff, Residents, Fellows or Students

- **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.
  - 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.
Any Questions
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:
  - Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or
  - Iliana De La Cruz, RMC, Director Office of Billing Compliance
    - Phone: (305) 243-5842
    - Officeofbillingcompliance@med.miami.edu

- Also available is The University’s fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24 hours a day, seven days a week).
- Office of billing Compliance website: www.obc.med.miami.edu