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.
False Claims Act : United States Code Title 31 §3729-3733

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.
MEDICAL NECESSITY

Quality & Cost:
Emphasis on Pay-for-Performance
Quality & Cost: Emphasis on Pay-for-Performance PQRS & Meaningful Use

- 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 will 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].”
Pathology Diagnosis Coding

When choosing diagnosis codes for professional billing -

- Definitive diagnosis should be assigned to the highest degree of specificity, whenever possible
- If the findings are inconclusive – code the Signs and Symptoms which prompted the service
- Preventive services – screenings – document screening nature of the service

Diagnosis can not be assigned on basis of “rule out”, “possible” or “probable” history or findings
ICD-9 CM Coding: Symptoms

• In cases where the clinical findings are negative diagnosis should be assigned based on Signs and Symptoms which prompted the service

• Examples:

  • Breast
    • Lump = 611.72
    • Abnormal mammogram = 793.8
  
  • Prostate
    • Elevated PSA = 790.93
  
  • G.I.
    • Abdominal pain = 789.00
    • Diarrhea = 787.91
    • Heartburn = 787.1

Assignment of diagnosis based on “Rule out” condition would falsify patient’s medical history and could negatively effect patient health coverage from the insurance carrier’s perspective

Therefore, in case of negative findings, providers should report services with codes representing signs and symptoms
All diagnostic tests “must be ordered by the physician who is treating the beneficiary.” An “order” as a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

• A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility

• A telephone call by the treating physician/practitioner or his/her office to the testing facility

• An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

Note: If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records. On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient’s medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.
Diagnosis Coding & Medical Necessity

• Justification of medical services rendered to a patient - Diagnosis codes indicate the reason for the encounter
  • Document the most accurate diagnosis or signs /symptoms representing clinical conditions rendering treatment / services on a given DOS to the highest specificity
  • Physician claims require diagnosis codes and are often utilized on reviews to support medical necessity thru LCDs and NCDs, especially for radiology
• If the clinical findings of the test are inconclusive or negative – code Signs or Symptoms which prompted the encounter
• Do not choose diagnoses codes – if condition is described as “probable”, “possible” or “rule out”
• All requests for diagnostic testing must be documented in the reports and specify:
  • diagnosis (if confirmed) or signs or symptoms
Physicians submitting charges to the insurance carriers are “expected to know” that services will be considered “not medically necessary” if:

- There is a published policy outlining the coverage, or
- A given service was previously denied
  - due to diagnosis code listed on the claim
  - lack of appropriate modifiers
  - due to frequency limitation
Interpretation Report for Clinical Lab Tests

Medicare approved a limited number of clinical lab tests for professional fee billing by Pathologists, based on the fact that such tests frequently require the interpretation. The physician should bill with modifier -26 for these clinical lab tests in the outpatient/inpatient hospital setting.

- 83020 Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)
- 84165 Protein; electrophoretic fractionation and quantitation, serum
- 84166 electrophoretic fractionation and quantitation, other fluids with concentration (eg, urine, CSF)
- 84181 Western Blot, with interpretation and report, blood or other body fluid
- 84182 Western Blot, with interpretation and report, blood or other body fluid, immunological probe for band identification, each
- 85390 Fibrinolysins or coagulopathy screen, interpretation and report
- 85576 Platelet, aggregation (in vitro), each agent
- 86153 Cell enumeration using immunologic selection & identification in fluid specimen (eg., circulating tumor cells in blood)
- 86255 Fluorescent noninfectious agent antibody; screen, each antibody
- 86256 titer, each antibody
- 86320 Immunoelectrophoresis; serum
- 86325 other fluids (eg, urine, cerebrospinal fluid) with concentration
Interpretation Report for Clinical Lab Test, continued

- 86327 crossed (2-dimensional assay)
- 86334 Immunofixation electrophoresis; serum
- 86335 other fluids with concentration (eg, urine, CSF)
- 87164 Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection
- 87207 Smear, primary source with interpretation; special stain for inclusion bodies or parasites
  (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)
- 88371 Protein analysis of tissue by Western Blot, with interpretation and report;
- 88372 immunological probe for band identification, each
- 89060 Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)
Flow Cytometry

General Information

- CPT codes for Flow Cytometry:
  - 88184 - Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only \textit{first marker}
  - +88185 - \textit{each additional marker} (Can only be billed in addition to the CPT 88184)

Technical Component

Usually reported by a facility that owns/leases the equipment (hospitals or independent labs)

Professional Component

Attending physician report

- 88187 - Flow cytometry \textit{interpretation} 2 to 8 markers
- 88188 - Flow cytometry \textit{interpretation} 9 to 15 markers
- 88189 – Flow cytometry \textit{interpretation}; 16 or more markers

Each marker must be documented in the report
Pathology Consultations: CPT 80500 & 80502

Pathology service is considered consultative only when all these conditions are satisfied

1. The service is requested by the patient's attending physician;

2. Pathologist service relates to a test result that lies outside the clinically significant normal or expected range in view of the condition of the patient;

3. Pathologist creates a written narrative report included in the patient's medical record; and

4. The service requires the exercise of medical judgment by the consultant physician.

5. **NO STANDING ORDERS ALLOWED!**
Pathology - Consultations

- Pathology consultation results from a request from the attending physician for assistance in interpreting the results of a test (or tests) and advice on the plan of care for the patient, in light of the patient’s clinical condition.

- Consultations include a written report containing the interpretive judgment and clinical recommendations of the pathologist.

- Without documentation of the request – the service can not be classified as “Consultation”

  • Similarly, oral communication of results of pathological consultation back to the referring physician w/o written report would not qualify as “consultation”
Pathology Consultations  CPT 80500 & 80502

When should you report 80500 vs. 80502?

**CPT 80500 - Limited**

 Represents a limited service without review of the patient’s medical history and medical records

**CPT 80502 - Extensive**

 Should be used to report comprehensive service for complex diagnostic problem. Documentation should include review of patient’s history and medical records.
Reporting Prostate Needle Biopsies: The key phrase in the new descriptor is “any method.”

- Effective Jan. 1, 2014 it makes no difference how the biopsies are extracted.
  - Code based solely on the number of individual biopsies that are presented for examination.
  - If the number of individually identified and diagnosed prostate needle biopsies for a case is 1 through 9, report each biopsy with CPT code 88305 (e.g., 88305 x 6 or 88305 x 8);
  - However, if the number of individually identified and diagnosed prostate needle biopsies for a case is 10 through 20, report just one unit of HCPCS Level II code G0416.

The surgical approach used by the referring physician to extract the biopsies isn’t relevant to application of the prescribed coding scheme.
**Prostate Needle Biopsy Tissue Exam**

**88305** Level IV – Surgical pathology, gross and microscopic examination [e.g., prostate needle biopsy] [1 to 9 specimens, each separately identified, diagnosed and reported biopsy]

- Report one unit of code 88305 per each separately identified, diagnosed and reported biopsy (e.g., 88305x2, 88305 -26x4 etc.)

**G0416** Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 10 to 20 specimens

**G0417** Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 21 to 40 specimens

**G0418** Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 41 to 60 specimens

**G0419** Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, > 60 specimens

- Do not report 88305 together with G0416-G0419 for the same prostate needle biopsy case. G0416-G0419 is reported with 1 unit.
- Each code has a global, professional and technical component. Use the applicable modifier 26 or TC.
Surgical Pathology Levels I-IV

General Comments:

- **Level I** represents gross examination only
- **Levels II-VI** represent gross and microscopic examination of the specimen
  - These levels are differentiated based on the anatomical origin of the specimen

Pathology reports must be detailed enough to allow for accurate code selection
CPT Coding - Guidelines

- Guidelines:
  - There is no limit to the number of 88300-88309 codes for a given case
  - The reimbursement is per code NOT per claim
  - The path report must clearly disclose through separate exam description (gross or micro) and final pathologic diagnosis the individual, separately identified specimens being charged
CPT Coding – “Per Specimen”

“Specimen” is defined as:

- received in own separately labeled container OR
- uniquely identified by suture, clip, inking, or other foreign feature OR
- pathology requisition or specimen tag provides correlative information OR
- distinguishable by size, shape, or other anatomic feature and Path requisition or provides correlative information

“Separate Specimen”

- submitted at a different time than other specimens, for example, with a staging procedure in surgery
  - Example: an incisional biopsy followed by excision
- is anatomically, functionally, or in some other way distinct from another specimen in the container, as determined by gross or microscopic exam and a separate pathologic diagnosis is dictated
  - Example: vas deferens vs. hydrocele; lipoma vs. hernia sac
Pathology ICD-9 Coding: “Per Specimen”

Please note the following:

- **NOT** required for each specimen/container
- Often, one code adequately identifies the need for care, **AND**
- The first diagnosis code should represent the most important reason for care
  - *Reason:* Usually only the first diagnosis code per line of service is referred to by claim processing software
CPT Coding – “Complete Specimens”

Specimens that consist of two or more tissue types but are billed as one complete specimen

- Abortion (including POC)
- Bone Exostosis
- Cholesteatoma
- Conjunctiva
- Extremity amputation
- Fetus w/dissection

- Fingers
- Fissure/Fistula
- Joint resection
- Placenta
- Pterygium
- Toe(s)
CPT Coding – Lymph Nodes

Note the following:

• Lymph nodes are **NOT** separately chargeable if “attached to” the primary specimen
• Lymph nodes are **NOT** separately chargeable with a mandatory bundling scenario
• “Sentinel node” is a separate “procedure” 88307 for each container
• For single lymph node, **NOT** for lymphoma protocol, use CPT 88305 (biopsy)
• Two or more countable nodes from a “region” translate to 88307
• If only fat or adipose tissue, use 88304
New AMA/CMS IHC Stain Codes (88342, 88343, G0461 & G0462)

AMA 2014 CPT Codes 88342 and 88343: Qualitative IHC

88342 Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide

- **88343** each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)
  
  *(When multiple antibodies are applied to the same slide, use one unit of 88342 for the first separately identifiable antibody and one unit of 88343 for each additional identifiable antibody)*

**Medicare** pays for medically necessary qualitative IHC procedures by laboratories and physicians using HCPCS Level II codes G0461 and G0462 starting Jan. 1, 2014.

- **G0461** Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain
- **G0462** each additional single or multiplex antibody stain (List separately in addition to code for primary procedure)
88343: For Reporting in Conjunction With Qualitative IHC Cocktail Stains

- As the parenthetical note in the codebook says, code 88343 is to be reported when “multiple antibodies are applied to the same slide,” and that precisely describes an IHC cocktail stain.
  - Said another way, code 88343 is reportable only if the lab prepares just one slide using an IHC cocktail stain that permits the pathologist to tell if the tissue is positive for two or more different antibodies by looking through the microscope just one time.
- An IHC cocktail stain with individually interpretable antibodies is properly reported with one unit of 88342 for the first antibody on the slide and one unit of 88343 for each additional separately interpreted antibody on the same slide.
Three misconceptions about the AMA’s policy for qualitative IHC procedures on and after Jan. 1, 2014 that have come to our attention.

1. Only one unit of 88342 is allowed per date of service:
   - This statement is false. Code 88342 is for the first IHC stain (qualitative) per tissue block on any one slide. A high percentage of tissue specimens require more than one IHC stain (i.e., more than one antibody) for a definitive diagnosis, and with the vast majority of IHC stains applied on a one-stain-one-slide basis, that means providers bill multiple units of 88342 with the same date of service in medically necessary situations with very high frequency. An insurer that limited 88342 charges to one per patient per date of service would either be misinterpreting the AMA guidance for that code or not fully appreciating the intra-lab protocols that actually apply to immunohistochemistry.
IHC Stain Codes (88342, 88343, G0461 & G0462)

Three misconceptions about the AMA’s policy for qualitative IHC procedures on and after Jan. 1, 2014 that have come to our attention.

2. One unit of 88343 is allowed for each additional IHC antibody stain per date of service:

   - This statement is false. According to the AMA codebook, code 88343 is properly reported only in the situation where two or more antibodies are separately interpretable on one slide that’s examined by the pathologist. There are few IHC cocktail and multiplex stains on the market today that fulfill this criterion, with the PIN-4 cocktail stain likely being the best known. Unless a lab or pathologist is working with a cocktail or multiplex stain, the proper code to use when billing multiple qualitative IHC stains is 88342 (i.e., multiple units of 88342).
Three misconceptions about the AMA’s policy for qualitative IHC procedures on and after Jan. 1, 2014 that have come to our attention.

3. A different quantity edit is appropriate depending on the component modifier:

- This statement is false. The AMA does not distinguish among the global, professional only (modifier 26), and technical only (modifier TC) services for codes 88342 and 88343 so far as allowed quantity or basic policy are concerned. The same quantity and coverage edits should be invoked in relation to all three types of 88342 or 88343 charge.
When Stains are Not Adequate to Contribute to Diagnosis, Can We Still Bill?

- If the pathologist felt the stain was necessary, but later found out that the stain was not adequate to contribute to the diagnosis, the stain would still be billable.
- Suggest documenting the stain and add language that the stain procedure “inconclusive results” or similar statement.
The vast majority of IHC stains test for one—and only one—antigen. Consequently, the most common scenario is for the lab to apply one unique stain to one unique slide such that the pathologist evaluates only one antibody reaction at a time under the microscope.

- For example, if the pathologist orders CK5 and p63 IHC stains on a particular specimen, she’ll receive two separately labeled slides and have to look through the microscope two times to determine if the tissue is positive for the CK5 and/or the p63 antibodies.

The AMA allows one unit of charge (88342) per each different (unduplicated) qualitative IHC antibody stain (i.e., one antibody per slide) per tissue block.

- For the testing scenario just cited, the AMA prescribes one unit of 88342 for the CK5 stain and another unit of 88342 for the p63 stain—one separately identifiable antibody on each of two different slides from one tissue block.)
Surgical Pathology Consultations: 88321-88334

- **88321** – Consultation and report on referred *slides prepared elsewhere*
- **88323** – Consultation and report on referred *material requiring preparation of slides*
- **88325** – Consultation, comprehensive, *with review of records and specimens, with report on referred material*

Documentation in the pathology report must support the choice of code, thus, make sure the report includes appropriate documentation.

These codes are used to report consultations on material referred from another source.
Documentation to Substantiate Pathology Consult Request and/or Special Stains

- There are no set format for consultation. A request must be made, the service must be performed and a report must be issued.

- Because any special stains or other add-on procedures that you order from your lab are separately chargeable with a consultation case, it’s crucial that you document:
  - (a) what it is that was ordered from your lab;
  - (b) why that item is medically indicated for the case; and
  - (c) what you found from the add-on procedure. Consultation reports often talk about impressions from special stains, IHC, flow cytometry, and the like. It is extremely important that coders and auditors be able to readily tell with certainty whether the preparation you’re talking about was developed at the outside facility or in your lab.
Elements of the report

Clinical Information must include
- Referring Physician
- Patient Demographics
- Clinical signs or symptoms or personal history of disease (reason the test was ordered)

Body of the report should include
- Description of the specimen, procedure(s) including stain panel, add’l studies etc.

Diagnosis
- If findings are negative – coding is based on signs or symptoms (indicated in clinical hx)
- Diagnosis can not be assigned on basis of “rule out”, “possible” or “probable” history or findings
Guidelines for Teaching Physicians, Interns and Residents
Pathology Services

In the teaching setting the attending pathologist qualifies for reimbursement if:

- The teaching physician's signature is the only signature on the report (Carrier will assume that the author/attending is indicating that he or she personally performed the interpretation).

- If a resident prepares and signs the report, the teaching physician must indicate that he or she has personally reviewed the specimen and the resident's interpretation and either agrees with it or edits the findings. “I personally reviewed the specimen and agree with the final report”.

In cases where the documentation shows simply a countersignature of the resident's interpretation by the teaching physician – no charges should be submitted by the attending physician.
Pathology TP Sample Attestations

- Surgical if there is no gross and Flow Cytometry and Peripheral Smear Consultations:
  - Microscopic only: ‘All microscopic slides and flow cytometry data (if applicable) have been reviewed and interpreted by the signing pathologist’
- Surgical cases with gross and microscopic:
  - “The gross description and all microscopic slides have been reviewed and interpreted by the undersigned pathologist”
- Surgical cases with gross only:
  - “The gross specimen has been personally reviewed and interpreted by the undersigned pathologist”
Pathology TP Sample Attestations

• Coagulation Consultations:
  • 'These tests have been reviewed and interpreted by the signing pathologist'

• Hematopathology:
  • 'The gross description, flow cytometry data (if applicable) and all microscopic slides have been reviewed and interpreted by the undersigned pathologist'

• Surgical Consultation With Resident: PLEASE ensure your attestation is present to bill
When to Use Modifiers

- **Bundled** – verb: to collect or gather up into a mass (Oxford Dictionary)
  - A “bundled” service includes all of the steps necessary to complete a given procedure.

- **Unbundling** - occurs when 2 or more CPT codes are used to describe a service when a single, more comprehensive code exists that accurately describes the service performed.

**Fraud Alert**

Unbundling satisfies the OIG’s definition of a false or fraudulent claim.

Improper use of modifier –59 may result in “unbundling” of services.
Modifier 59 Definition

- Distinct procedural service Designates instances when distinct and separate multiple services are provided to a patient on a single date of service.
- *TIP Strictly a billing modifier used to break the National Correct Coding Initiative (NCCI) edits.
  - Identifies procedures/services that are not normally reported together, but are appropriate under the circumstances.
  - Overrides the correct coding edit. Documentation must substantiate utilization.
For all intent and purposes, Medicare has wrenched control over it from the AMA, so its primary use is to denote situations where a NCCI edit or a Medically Unlikely Edit (MUE) limit is appropriately bypassed due to the facts at hand.

Medicare Part B contractors also want the 59 modifier used to declare that multiple units of the same CPT code being reported on the same day are all medically necessary.
Modifier – 91

If an ordering physician requests a laboratory test that requires that several of the same services (CPT code) be performed for the same beneficiary on the same day, **modifier -91 should be used** to indicate that multiple clinical diagnostic laboratory tests were done on the same day. (This modifier should not be used when multiple tests are described under a single code, e.g., glucose tolerance test.)

**Example:**

An arterial blood sample is drawn from a patient at three different intervals on the same day, and the blood testing is performed three times that same day CPT code 82803 – Gas, blood, any combination of pH, PCO2, PO2, CO2, HCO3 (including calculated 02 saturation)

Report the CPT code 82803 on the line item and code the modifier ‘-91’ after the CPT code. The information would appear as “82803-91” on the line item.
Modifier – 91

Frequency of Services

- Frequency of laboratory test is always a consideration. Carriers may request documentation when the frequency of an individual test appears to be not reasonable and necessary for a particular patient.

When modifier -91 should not be used?

- CPT manual indicates that modifier-91 should not be used in the following cases:
  - When tests are rerun to confirm initial results;
  - Multiple services were rendered due to testing problems with specimens or equipment;
  - Any other reason when a normal, one-time reportable result is all that is required
  - When there is a separate code indicating that series of test results were performed
Interprofessional Consultations

• The services will typically be provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be possible. The written or verbal request, its rationale, and the conclusion for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient’s medical record.

• Medicare allowable $0.00
Interprofessional Consultations

- The services will typically be provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be possible. The written or verbal request, its rationale, and the conclusion for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient’s medical record.

- Medicare allowable $0.00
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
ICD-9 vs 10: Cervical CIN III, Severe Dysplasia

ICD-9: 233.1 (Carcinoma in situ, cervix uteri)
ICD-10: Do6 (Carcinoma in situ of cervix uteri) as follows:

- Do6.0 – Carcinoma in situ of endocervix
- Do6.1 – Carcinoma in situ of exocervix
- Do6.7 – Carcinoma in situ of other parts of cervix
- Do6.9 – Carcinoma in situ of cervix, unspecified

Physician Documentation:

- The key difference between 233.1 and the Do6 category is the specific location of the lesion “endocervix, exocervix, “other parts,” or unspecified. Pathologists will need to move the lesion location information forward in the pathology report if specified by the surgeon’s op note.
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