2015 Radiation Therapy Code Revisions

Not all of the newly introduced radiation therapy CPT® codes for 2015 will be adopted for MPFS use in 2015

• The timing of the release of new codes by the AMA and RUC is creating an issue for CMS

• Postponement until 2016 will allow for proper valuation and review of impact on stakeholders

• Deleted 2014 codes for treatment delivery, planning and IGRT will still be deleted; however, new G codes will be used for some of the new replacement and/or revised codes for 2015
2015 Radiation Therapy Code Revisions

- For CY2015 the new isodose planning codes were accepted and made final and implemented effective January 1, 2015

- The table details the crosswalk from the deleted code to the new codes

<table>
<thead>
<tr>
<th>2014 Codes</th>
<th>Description</th>
<th>2015 Codes (Pro)</th>
<th>2015 Tech (Freestanding)</th>
<th>2015 Global (Freestanding)</th>
<th>2015 Codes OPPS (Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>77305</td>
<td>Teletherapy isodose plan simple</td>
<td>77306-26</td>
<td>77306-TC</td>
<td>77306</td>
<td>77306</td>
</tr>
<tr>
<td>77310</td>
<td>Teletherapy isodose plan intermediate</td>
<td>Deleted</td>
<td>Deleted</td>
<td>Deleted</td>
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</tr>
<tr>
<td>77315</td>
<td>Teletherapy isodose plan complex</td>
<td>77307-26</td>
<td>77307-TC</td>
<td>77307</td>
<td>77307</td>
</tr>
<tr>
<td>77326</td>
<td>Brachytherapy isodose plan; simple</td>
<td>77316-26</td>
<td>77316-TC</td>
<td>77316</td>
<td>77316</td>
</tr>
<tr>
<td>77327</td>
<td>Brachytherapy isodose plan; intermediate</td>
<td>77317-26</td>
<td>77317-TC</td>
<td>77317</td>
<td>77317</td>
</tr>
<tr>
<td>77328</td>
<td>Brachytherapy isodose plan; complex</td>
<td>77318-26</td>
<td>77318-TC</td>
<td>77318</td>
<td>77318</td>
</tr>
</tbody>
</table>
2015 Radiation Therapy Code Revisions

• The treatment delivery codes were also changed, and based on the complexity of the case and not on the energy utilized.

<table>
<thead>
<tr>
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<th>2015 Codes OPPS (Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>77402</td>
<td>Radiation tx &gt;1 MEV; simple</td>
<td>N/A</td>
<td>G6003</td>
<td>G6003</td>
<td>77402</td>
</tr>
<tr>
<td>77403</td>
<td>Radiation tx &gt;1 MEV; simple</td>
<td>N/A</td>
<td>G6004</td>
<td>G6004</td>
<td>77402</td>
</tr>
<tr>
<td>77404</td>
<td>Radiation tx &gt;1 MEV; simple</td>
<td>N/A</td>
<td>G6005</td>
<td>G6005</td>
<td>77402</td>
</tr>
<tr>
<td>77406</td>
<td>Radiation tx &gt;1 MEV; simple</td>
<td>N/A</td>
<td>G6006</td>
<td>G6006</td>
<td>77402</td>
</tr>
<tr>
<td>77407</td>
<td>Radiation tx &gt;1 MEV; intermediate</td>
<td>N/A</td>
<td>G6007</td>
<td>G6007</td>
<td>77407</td>
</tr>
<tr>
<td>77408</td>
<td>Radiation tx &gt;1 MEV; intermediate</td>
<td>N/A</td>
<td>G6008</td>
<td>G6008</td>
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<tr>
<td>77409</td>
<td>Radiation tx &gt;1 MEV; intermediate</td>
<td>N/A</td>
<td>G6009</td>
<td>G6009</td>
<td>77407</td>
</tr>
<tr>
<td>77411</td>
<td>Radiation tx &gt;1 MEV; intermediate</td>
<td>N/A</td>
<td>G6010</td>
<td>G6010</td>
<td>77407</td>
</tr>
<tr>
<td>77412</td>
<td>Radiation tx &gt;1 MEV; complex</td>
<td>N/A</td>
<td>G6011</td>
<td>G6011</td>
<td>77412</td>
</tr>
<tr>
<td>77413</td>
<td>Radiation tx &gt;1 MEV; complex</td>
<td>N/A</td>
<td>G6012</td>
<td>G6012</td>
<td>77412</td>
</tr>
<tr>
<td>77414</td>
<td>Radiation tx &gt;1 MEV; complex</td>
<td>N/A</td>
<td>G6013</td>
<td>G6013</td>
<td>77412</td>
</tr>
<tr>
<td>77416</td>
<td>Radiation tx &gt;1 MEV; complex</td>
<td>N/A</td>
<td>G6014</td>
<td>G6014</td>
<td>77412</td>
</tr>
</tbody>
</table>
2015 Radiation Therapy Code Revisions

- It is important to note that the IMRT codes changed, and now includes the technical “charge” guidance and tracking.

<table>
<thead>
<tr>
<th>2014 Codes</th>
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<th>2015 Codes (Pro)</th>
<th>2015 Tech (Freestanding)</th>
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<th>2015 Codes OPPS (Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>77418</td>
<td>IMRT radiation tx (simple)</td>
<td>N/A</td>
<td>G6015</td>
<td>G6015</td>
<td>77385</td>
</tr>
<tr>
<td>77418</td>
<td>IMRT radiation tx (complex)</td>
<td>N/A</td>
<td>G6015</td>
<td>G6015</td>
<td>77386</td>
</tr>
</tbody>
</table>

- Physicians may still bill for the professional component IGRT with IMRT if the service is ordered, medically necessary and properly documented.
2015 Radiation Therapy Code Revisions

• The image guidance codes (76950, 77421 and 0197T) were deleted and combined into a new code.

<table>
<thead>
<tr>
<th>2014 Codes</th>
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<th>2015 Codes (Pro)</th>
<th>2015 Tech (Freestanding)</th>
<th>2015 Global (Freestanding)</th>
<th>2015 Codes OPPS (Hospital)</th>
</tr>
</thead>
<tbody>
<tr>
<td>76950</td>
<td>Echo guidance radiotherapy</td>
<td>G6001-26</td>
<td>G6001-TC</td>
<td>G6001</td>
<td>77387</td>
</tr>
<tr>
<td>77421</td>
<td>Stereoscopic x-ray guidance</td>
<td>G6002-26</td>
<td>G6002-TC</td>
<td>G6002</td>
<td>77387</td>
</tr>
<tr>
<td>0197T</td>
<td>Intra-fraction localization and tracking</td>
<td>G6017-26</td>
<td>G6017-TC</td>
<td>G6017</td>
<td>77387</td>
</tr>
</tbody>
</table>

• 77014 was not deleted, but per AMA it is no longer billable for IGRT. Still may be reported for treatment planning CTs. For IGRT report 77387, for treatment planning report 77014-TC.
Supervision Requirements
What is “Supervision”? 

CMS defines three levels of physician supervision for hospital outpatient departments:

• General supervision: The physician or non-physician practitioner (NPP) must be available by telephone to provide assistance and direction if needed.

• Direct supervision: The physician or NPP providing supervision must be “immediately available” and “interruptible” to provide assistance and direction throughout the performance of the procedure; however, he or she does not need to be present in the room when the procedure is performed.

• Personal supervision: The physician or NPP must be in attendance in the room during the procedure.
Supervision Requirements

Chemotherapy and radiation therapy require direct supervision

• All therapeutic services are subject to CMS’s supervision requirements. Under these requirements, both chemotherapy and radiation therapy require direct supervision in both the hospital outpatient and freestanding settings.
Supervision Requirements

Physicians and NPPs can provide supervision in hospital outpatient departments

- CMS states that a physician or NPP, such as a nurse practitioner (NP) or physician assistant (PA), must provide direct supervision of therapeutic services. The person providing supervision must be permitted to do so under state law, scope of practice regulations, and their hospital-granted privileges. In addition, he or she must have sufficient knowledge and training to be able "to furnish assistance and direction, not merely manage an emergency."
Supervision Requirements

Does radiation therapy have special requirements?

- CMS does not explicitly state that radiation therapy must be supervised by a radiation oncologist or trained NP, and although many providers have asked for clarification on radiation therapy requirements, CMS has declined to provide clarification. It states only that it requires that “the supervisory physician or non-physician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the services or procedure...The supervisory responsibility is more than the capacity to respond to an emergency...”

- If your hospital-based cancer program is currently providing radiation therapy services without specialist supervision, your program leaders should consult with your institution's legal counsel to formulate a policy that they feel is clinically defensible.
More stringent requirements in the freestanding setting

- CMS’s supervision requirements set a higher bar for physician offices and freestanding centers than for hospital outpatient departments. Whereas CMS allows NPPs to provide supervision in hospital outpatient departments, a physician is required to supervise these services in the freestanding setting.

- In addition, CMS does not require the supervising practitioner in the hospital outpatient setting to be physically present in the same office suite, just that he or she is "immediately available." In contrast, the supervising physician in the freestanding setting must be present in the office suite or center.
Supervision Requirements

For example, if radiation therapy services were being provided in a hospital outpatient department and the radiation oncologist who was supervising those therapeutic services left the hospital campus, a qualified physician or physician practitioner would need to be immediately available to supervise the procedures.

If there is no qualified supervising physician immediately available, no radiation therapy services provided during his/her absence can be covered by Medicare. The services covered under this benefit also include materials and services of technicians.
Documentation Requirements

Radiation Oncology
Documentation Requirements

Please ensure orders are written for any service you are asking someone else to perform. These include:

• Initial Simulations
• Set up Simulations
• Weekly Physics Checks
• Dose Calculations
• Physics Consult
• IGRT

Remember, if these services were not ordered, the professional component cannot be billed by you and the technical portion cannot be billed by the hospital.
Documentation Requirements
Initial Simulation

Documentation required:

• Order to perform service

• Written record of procedure and evidence on physician participation

• Images
Documentation Requirements Verification Simulation

Simulation provided to verify the accuracy of custom blocks and treatment parameters, prior to beginning a treatment.

Requires verification of all treatment ports prior to start of treatment

Documentation required:

• Order to perform service
• Written record of procedure
• Images
• Evidence of image review by physician
ASTRO FAQ’s for 2015
**Coding Question:** How do we report image guidance with IMRT using the new CPT codes in 2015?

**Coding Answer:** The new IMRT treatment delivery CPT codes (77385 and 77386) include guidance and tracking, when performed. The technical component of IGRT (77387-TC) is packaged into the IMRT service with which it is performed, and is not reported separately in either the freestanding or hospital setting. However, the professional component (PC) of IGRT can still be reported.

In the freestanding setting, the physician reports the correct IMRT code and the professional component (PC) of IGRT. In the hospital setting, the hospital reports the correct IMRT code, and the physician reports the PC of IGRT. To report the PC, a physician would typically bill 77387 with the -26 modifier attached. However, CPT code 77387 did not receive a value in the MPFS in 2015. Therefore, to report the PC of IGRT services in 2015, the physician may attach the -26 modifier to one of the following codes: G6001, G6002, G6017 and/or 77014 depending on the modality used to perform the IGRT services.

ASTRO anticipates most private payers will accept G-codes in 2015; however, certain private payers may only accept 77387-26. **It is extremely important to check with your payer to see whether they will be accepting the new CPT codes or HCPCS G-codes before submitting claims.**
Coding Question: A patient undergoing IMRT for prostate cancer has tracking using transponders implanted in the prostate. The radiation oncologist provides direct supervision and reviews radiographic imaging daily. What are the correct technical and professional IMRT and IGRT codes?

Coding Answer: In a freestanding setting or in the hospital setting, when using tracking transponders, the physician will report 77385 and G6017-26, or 77387-26 if accepted by the payer. (All new codes)

77385      Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
G6017      Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment
77387      Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed
ASTRO FAQ’s for 2015

Coding Question: The new CPT codes for reporting a teletherapy isodose plan (77306-77307) and a brachytherapy isodose plan (77316-77318) clearly state that 77300 is now bundled into those new codes. Has there been any bundling of 77300 for IMRT planning (77301) and 3-D planning (77295)? Can we bill 77300 with 77321 (Special teletherapy port plan, particles, hemibody, total body)?

77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician

Coding Answer: CPT code 77300 was not bundled into either 77301 or 77295 and can still be reported with these codes. However, a separate 77300 cannot be reported with CPT code 77321. The work of 77300 is already captured in the planning code (77321). If a particle beam is planned for delivery without an isodose plan (77321, 77306 or 77307), then CPT code 77300 can still be reported. If the particle beam plan rises to the level of 77295 or 77301, CPT code 77300 can be utilized.
Coding Question: For HDR cases, CPT code 77300 is now included in the isodose planning codes (77316-77318). Are the subsequent decay calculations billable with additional 77300s?

Coding Answer: Yes, because subsequent isodose plans are not being billed.
ASTRO FAQ’s for 2015

• **Coding Question:** When the physician is billing for the professional component (PC) of IGRT via cone beam CT in the hospital, is the correct code 77014-26 or 77387-26 for 2015?

  • 77014  Computed tomography guidance for placement of radiation therapy fields
  • 77387  Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

• **Coding Answer:** 77387-26 did not receive a value in the MPFS in 2015. Therefore, to report the PC associated with cone beam CT (77014) in 2015, it is appropriate to report 77014-26. ASTRO expects that 77387-26 will receive a value in the 2016 MPFS and can be reported starting January 1, 2016. Once there is a value associated with the professional component of 77387, it will no longer be appropriate to report 77014 for IGRT services. ASTRO anticipates most private payers will accept 77014-26 in 2015; however, certain private payers may only accept 77387-26. It is extremely important to check with your payer to see whether they will be accepting the new CPT codes or HCPCS G-codes before submitting claims.
• **Coding Question:** Can a physician bill anything besides an Evaluation and Management (E/M) code with superficial radiation therapy (77401-Radiation treatment delivery, superficial and/or ortho voltage, per day)?

• **Coding Answer:** The following codes cannot be reported with 77401 as of January 1, 2015, regardless of whether your payer accepts the new CPT codes or the G-codes: clinical treatment planning (77261, 77262, 77263), treatment devices (77332, 77333, 77334), isodose planning (77306, 77307, 77316, 77317, 77318), physics consultation (77336), or radiation treatment management (77427, 77431, 77432, 77435, 77469, 77470, and 77499). There are no exclusions against reporting simulation codes (77280-77290) or basic dosimetry calculation (77300) with 77401; however, these codes may only be performed and reported when clinically indicated and appropriately documented. E/M codes may only be reported with 77401 when reporting 77401 alone.
ASTRO FAQ’s for 2015

Coding Question: When do we charge by energy when using the conventional radiation therapy treatment delivery codes (using the G-codes), and when do we use the new single energy CPT codes (77402, 77407, 77412)?

Coding Answer: The G-codes (G6003-G6016) assigned to the deleted conventional radiation therapy treatment delivery CPT codes (77402-77416) should be used to report treatment delivery under the Medicare Physician Fee Schedule in the freestanding office setting. Medicare payers and most private payers will be accepting G-codes in 2015. The new CPT treatment delivery codes should be reported in hospital based settings under the HOPPS. Additionally, some private payers may require reporting using the new CPT codes. It is extremely important to check with your payer to see whether they will be accepting the new CPT codes or HCPCS G-codes before submitting claims.
Documentation in the EHR - EMR
Volume of Documentation vs Medical Necessity

Annually OIG publishes its "targets" for the upcoming year. Included is EHR Focus and for practitioners could include:

Pre-populated Templates and Cutting/Pasting Documentation containing inaccurate or incomplete or not provided information in the medical record

- **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 actual service provided on the DOS only.
General Principals of Documentation

• All documentation must be legible to all readers. Illegible documents are considered not medically necessary if it is useless to provide a continuum of care to a patient by all providers. Documentation is for the all individuals not just the author of the note.

• Per the Centers for Medicare and Medicaid services (CMS) practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
  • CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the date of service.
  • Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done, and this includes a signature.

• An addendum to a note should be dated and timed the day the information is added to the medical record and only contain information the practitioner has direct knowledge is true and accurate.
Inpatient, Outpatient and Consultations

Evaluation and Management E/M

Documentation and Coding
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 does not affect the designation of a new patient.
E/M Key Components

• History (H) - Subjective information
• Examination (E) - Objective information
• Medical Decision Making (MDM) – The assessment, plan and patient risk

The billable service is determined by the combination of these 3 key components.
• All 3 Key Components are required to be documented for all E/M services.
• For coding the E/M level
  • New OP and initial IP require all 3 components to be met or exceeded and
  • Established OP and subsequent IP require 2 of 3 key components to be met or exceeded and one must be MDM.

When downcoded for “medical necessity” on audit, it is often determined that documented H and E exceeded what was deemed “necessary” for the visit (MDM.)
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) and History of Present Illness (HPI) are required to be documented for every patient for every visit

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 or reason for the encounter 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 in order to be counted towards the level of service billed.

  Focus upon present illness or reason for the visit!

• HPI drivers:
  • Extent of PFSH, ROS and physical exam performed

• NEVER DOCUMENT PATIENT HERE FOR FOLLOW-UP WITHOUT ADDITIONAL DETAILS OF REASON FOR FOLLOW-UP. This would not qualify as a CC or HPI.
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)

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic

ROS is an inventory of specific body systems in the process of taking a history from the patient. The ROS is designed to bring out clinical symptoms which the patient may have overlooked or forgotten. In theory, the ROS may illuminate the diagnosis by eliciting information which the patient may not perceive as being important enough to mention to the physician relative to the reason for the visit.
Past, Family, and/or Social History (PFSH)

• **Past history:** The patient’s past medical experience with illnesses, surgeries, & treatments. May also include review of current medications, allergies, age appropriate immunization status.

• **Family history:** May include a review of medical events in the patient’s family, such as hereditary diseases, that may place a patient at risk or specific diseases related to problems identified in the Chief Complaint, HPI, or ROS.

• **Social history:** May include age appropriate review of past and current activities, marital status and/or living arrangements, use of drugs, alcohol or tobacco and education.

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" for coding a level of E/M.**
Examination

4 TYPES OF EXAMS

- Problem Focused (PF)
- Expanded Problem Focused (EPF)
- Detailed (D)
- Comprehensive (C)
## Coding 1995: Physical Exam

### 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
1995 and 1997 Exam Definitions

**Problem Focused (PF):** 99231, 99212 or 99201

- ‘95: 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):** 99232, 99213 or 99202

- ‘95: 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):** 99233, 99221, 99214 or 99203

- ‘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)

**Comprehensive (C):** 99222, 99223, 99215 or 99204 and 99205

- ‘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.
Medical Decision Making (MDM)

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE TODAY!!

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 management options affecting today's visit. List each separate in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options:
  - “New” self-limiting: After the course of prescribed treatment is it anticipated that the diagnosis will no longer be exist (e.g. otitis, poison ivy, ...)
  - New diagnosis with follow-up or no follow-up (diagnosis will remain next visit)
  - Established diagnosis that stable, worse, new,

**Step 2:**
- Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.
  - Labs, radiology, scans, EKGs etc. reviewed or ordered
  - Review and summarization of old medical records or request old records
  - Independent visualization of image, tracing or specimen itself (not simply review of report)

**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.
  - # of chronic conditions and are the stable or exacerbated (mild or severe)
  - Rx’s ordered or renewed. Any Rx toxic with frequent monitoring?
  - Procedures ordered and patient risk for procedure

Note: The 2 most complex elements out of 3 will determine the overall level of MDM
MDM Step 3: Risk Table for Complication

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.
<table>
<thead>
<tr>
<th>Min Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-2, New –1 or 2, IP -1</td>
<td>• One self-limited / minor problem</td>
<td>• Labs requiring venipuncture • CXR EKG/ECG UA</td>
<td>• Rest • Elastic bandages • Gargles • Superficial dressings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-3, NEW-3 IP - 1</td>
<td>• 2 or more self-limited/minor problems • 1 stable chronic illness (controlled HTN) • Acute uncomplicated illness / injury (simple sprain)</td>
<td>• Physiologic tests not under stress (PFT) • Non-CV imaging studies (barium enema) • Superficial needle biopsies • Labs requiring arterial puncture • Skin biopsies</td>
<td>• OTC meds • Minor surgery w/no identified risk factors • PT, OT • IV fluids w/out additives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mod Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-4, NEW-4 IP-2</td>
<td>• 1 &gt; chronic illness, mod. Exacerbation, progression or side effects of treatment • 2 or more chronic illnesses • Undiagnosed new problem w/uncertain prognosis • Acute illness w/systemic symptoms (colitis) • Acute complicated injury</td>
<td>• Physiologic tests under stress (stress test) • Diagnostic endoscopies w/out risk factors • Deep incisional biopsies • CV imaging w/contrast, no risk factors (arteriogram, cardiac cath) • Obtain fluid from body cavity (lumbar puncture)</td>
<td>• Prescription meds • Minor surgery w/identified risk factors • Elective major surgery w/out risk factors • Therapeutic nuclear medicine • IV fluids w/additives • Closed treatment, FX / dislocation w/out manipulation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-5. NEW-5 IP –3</td>
<td>• 1 &gt; chronic illness, severe exacerbation, progression or side effects of treatment • Acute or chronic illnesses that may pose threat to life or bodily function (acute MI) • Abrupt change in neurologic status (TIA, seizure)</td>
<td>• CV imaging w/contrast, w/risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies w/risk factors</td>
<td>• Elective major surgery w/risk factors • Emergency surgery • Parenteral controlled substances • Drug therapy monitoring for toxicity • DNR</td>
</tr>
</tbody>
</table>
Using Time to Code Counseling /Coordinating Care (CCC)

Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is CCC. Time is only Face-to-face for OP setting.

Coding based on time is generally the exception for coding. It is typically used when there is a significant exacerbation or change in the patient’s condition, non-compliance with the treatment/plan or counseling regarding previously performed procedures or tests to determine future treatment options.

Required Documentation For Billing:
1. Total time of the encounter excluding separate procedure if billed
   • The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated to counseling / coordination of care
3. The specific nature of counseling/coordination of care for that patient on that date of service. A template statement would not meet this requirement.
Counseling /Coordinating Care (CCC)?

Documentation must reflect the specific issues discussed with patient present.

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”

• “I spent ____ minutes with the patient more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”

• “This entire ______ minute visit was spent counseling the patient regarding ________ and addressing their multiple questions.

Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.
Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents Fellows and Interns

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill
Evaluation and Management (E/M)

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

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

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

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

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

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

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

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

- E/M codes where more than 50% of the TP time spent counseling or coordinating care

Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical/optometry student must be re-performed and documented by a resident or teaching optometrist.
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
TP Guidelines for Procedures

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

*Example*: ‘*I was present for the entire procedure.*’

**Major** – (>5 Minutes)

- **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, which must be described) of the procedure and immediately available.*’
Diagnostic Procedures

• **RADIOLOGY AND OTHER DIAGNOSTIC TESTS**

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

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

• **A countersignature by the Teaching Physician to the resident’s interpretation is not sufficient documentation.**
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• The CPT descriptions of documentation requirements for many ophthalmic diagnostic tests include the phrase, ".

• . . with interpretation and report." Once the appropriate individual has performed the test, you must document your interpretation of the results somewhere in the medical records. This doesn't have to be anything elaborate.

• It may merely be a brief phrase indicating if a test is "normal," "stable from a previous test" or "mild superior arcuate defect."
Orders” Are Required For Any Diagnostic Procedure With a TC / 26 Modifier

• All services billed for interpretation must include an order (even as a notation in the encounter note for the DOS) and distinct report for in order to bill.

• For Medicare, the Interpretation and Report needs the Three C’s to be addressed:
  • Clinical Findings,
  • Comparative Data, when appropriate; and
  • Clinical Management

• There must be a written report that becomes part of the patient’s medical record and this should be as complete as possible.
Non-Physician Practitioners (NPP’s) or Physician Extenders

Who is a NPP?

Physician Assistant (PA)
Nurse Practitioner (NP)
NPP Agreements & Billing Options

- Collaborative agreement between the NPP and the group they are working with is required.
  - The agreement extends to all physicians in the group.
    - If the NPP is performing procedures it is recommended a physician confirm their competency with performance of the procedure.
- NPPs can bill independent under their own NPI # in all places-of-service and any service included in their State Scope of Practice.
  - Supervision is general (available by phone) when billing under their own NPI number.
  - Medicare and many private insurers credential NPPs to bill under their NPI.
  - Some insurers pay 85% of the fee schedule when billing under the NPP and others pay 100% of the fee schedule.
- Incident-to in the office (POS 11)
- Shared visit in the hospital or hospital based clinic (POS 21, 22, 23)
Shared Visits

• The shared/split service is usually reported using the physician's NPI.

• When an E/M service is a shared encounter between a physician and a NPP, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient and can be billed under the physician.

• If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the non-physician's NPI.

• Procedures **CANNOT** be billed shared
Shared Visits Between NPP and Physician

Shared visits may be billed under the physician's name if and only if:

1. The physician provides a medically necessary face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and

2. The physician personally documents in the patient's record the details of their face-to-face portion of the E/M encounter with the patient.

- If the physician does not personally perform and personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician's name and must be billed under the NPP.

- The NPP MUST be an employee (or leased) to bill shared. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician.
Not Shared

Billing Under The NPP NPI

• Does not require physician presence.
• Can evaluate and treat new conditions and new patients.
• Can perform all services under the state scope-of-practice.
• Can perform services within the approved collaborative agreement.
  • Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.
NPP and Resident / Fellow

• The collaborating supervising physician for NPP or Teaching Physician for the resident/fellow should administer and maintain documentation of a competency evaluation of the NPP or resident / Fellow to ensure that as the supervising Radiation Oncologist they, together with meeting any hospital requirements, approve the NPP or resident as capable of meeting the supervision of Radiation Oncology therapy services without their presence and are practicing within the State scope of practice and hospital-granted privileges. The NPI of the practitioner providing the supervision should be on the claim.

• Resident / Fellow: Physician Definition per Social Security Act Sec. 1832. [42 U.S.C. 1395k]
  • (r) The term “physician”, when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)). A physician can supervise diagnostic testing.
ICD-10

Looks like a go!
Diagnosis Coding
International Classification of Disease (ICD-10)

• ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
• ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
• ICD-10 CM will have 68,000 diagnosis codes and ICD-10 PCS will contain 76,000 procedure codes.
• This significant expansion in the number of diagnosis and procedure codes will result in major improvements including but not limited to:
  • Greater specificity including laterality, severity of illness
  • Significant improvement in coding for primary care encounters, external causes of injury, mental disorders, neoplasms, diabetes, injuries and preventative medicine.
  • Allow better capture of socio-economic conditions, family relationships, and lifestyle
  • Will better reflect current medical terminology and devices
  • Provide detailed descriptions of body parts
  • Provide detailed descriptions of methodology and approaches for procedures
Clinical Trials
Requirements for Billing Routine Costs for Clinical Trials

Effective for claims with dates of service on or after January 1, 2014 it is mandatory to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.

**Professional**

- For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02 (REF01=P4) (do not use CT on the electronic claim, e.g., 12345678) when a clinical trial claim includes:
  - ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  - **Modifier Q0** (investigational clinical service provided in a clinical research study that is in an approved clinical research study) and/or
  - **Modifier Q1** (routine clinical service performed in a clinical research study that is in an approved clinical research study), as appropriate (outpatient claims only).

**Hospital**

- For hospital claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:
  - Condition code 30;
  - ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  - Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

*Items or services covered and paid by the sponsor may not be billed to the patient or patient’s insurance, this is double billing.*
WHO IS RESPONSIBLE FOR OBTAINING APPROVAL FROM THE MAC(S) FOR AN INVESTIGATIONAL DEVICE EXEMPTION (IDE) CLINICAL TRIAL?

☐ The principal investigator (PI) is responsible for assuring that all required approvals are obtained prior to the initiation of the clinical trial. For any clinical study involving an IDE, the PI must obtain approval for the IDE clinical trial from the Medicare Administrative Contractor (MAC) for Part A / Hospital.

☐ Additionally, for clinical studies involving an IDE, the PI is responsible for communicating about the trial and the IDE to the Medicare Part B (physician) MAC.

☐ Once approval has been received by the MAC, the following needs to take place:
  • The Study must be entered in the Velos System within 48 hours.
  • The PI is responsible for ensuring that the IDE or the no charge device is properly set up in the facility charge master to allow accurate and compliant charging for that device before any billing will occur.
Investigational Device Exemption (IDE)

Hospital Inpatient Billing for Items and Services in Category B IDE Studies

• Payment for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved.

Routine Care Items and Services

• Hospital providers shall submit claims for the routine care items and services in Category B IDE studies approved by CMS (or its designated entity) and listed on the CMS Coverage Website, by billing according to the clinical trial billing instructions found in §69.6 of this chapter [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf), and as described under subsection D (“General Billing Requirements”).
Investigational Device Exemption (IDE)

Category B Device. On a 0624 revenue code line, institutional providers must bill the following for Category B IDE devices for which they incur a cost:

• Category B IDE device HCPCS code, if applicable
• Appropriate HCPCS modifier
• Category B IDE number

• Charges for the device billed as covered charges

• If the Category B IDE device is provided at no cost, outpatient prospective payment system (OPPS) providers must report a token charge in the covered charge field along with the applicable HCPCS modifier (i.e., modifier – FB) appended to the procedure code that reports the service to furnish the device, in instances when claims processing edits require that certain devices be billed with their associated procedures. For more information on billing ‘no cost items’ under the OPPS, refer to chapter 4, §§20.6.9 and 61.3.1 of this manual.
WHEN THE TRIAL ENDS OR REACHES FULL ENROLLMENT?

When the trial ends, whether due to reaching full enrollment or for any other reason, the PI must work with their department resource and/or the relevant Revenue Integrity Office(s) to inactivate the item in the charge master so that it may no longer be used.

If the device is approved by the FDA and is no longer considered investigational or a Humanitarian Device Exemption (HDE) and will continue to be used at UHealth, the PI must work with their department resource and/or the relevant Revenue Integrity Office(s) to inactivate the investigational device in the charge master and to ensure that a new charge code is built for the approved device. At this point, ongoing maintenance responsibility would transfer to the relevant Revenue Integrity Office(s).
CMS Quality Improvement Programs

- Meaningful Use (MU)
- Physician Quality Reporting System (PQRS)
- Value Based Payment Modifier (VBPM)
# CMS Quality Programs
## Medicare Part B Payment Reductions

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>POTENTIAL MEDICARE PAYMENT REDUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningful Use</td>
<td>1%</td>
</tr>
<tr>
<td>PQRS</td>
<td>1.5%</td>
</tr>
<tr>
<td>VBPM</td>
<td>4%</td>
</tr>
<tr>
<td>TOTAL PENALTIES</td>
<td>2.5%</td>
</tr>
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</table>
# 2015 PQRS Eligible Providers

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Practitioners</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>Physician Assistant</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>DO</td>
<td>Nurse Practitioner</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Doctor of Podiatric</td>
<td>Clinical Nurse Specialist*</td>
<td>Qualified Speech-Language Therapist</td>
</tr>
<tr>
<td>Doctor of Optometry</td>
<td>CRNA</td>
<td></td>
</tr>
<tr>
<td>DDS</td>
<td>Certified Nurse Midwife</td>
<td></td>
</tr>
<tr>
<td>DMD</td>
<td>Clinical Social Worker</td>
<td></td>
</tr>
<tr>
<td>Doctor of Chiropractic</td>
<td>Clinical Psychologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registered Dietician</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nutrition Professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audiologists</td>
<td></td>
</tr>
</tbody>
</table>
PQRS

- Reporting Requirements:
  - Reporting Period = Full CY
  - Report 9 Measures from 3 National Quality Strategy Domains

- Reporting Options:
  - Claims, EHR, Registry
  - Individual or GPRO

### NATIONAL STRATEGY DOMAINS

<table>
<thead>
<tr>
<th>Communication &amp; Care Coordination</th>
<th>Effective Clinical Care</th>
<th>Efficiency &amp; Cost Reduction</th>
<th>Patient Safety</th>
<th>Person &amp; Caregiver-Centered Experience &amp; Outcomes</th>
<th>Community/Population Health</th>
</tr>
</thead>
</table>
Physician Impact

*Workflow and documentation changes*

**TO DO:**
- Study Measure Specifications
- Ensure documentation meets measure requirements
- Bill PQRS quality code when required in MCSL/UChart
- Document chronic conditions/secondary diagnoses
- Use UChart Smart Phrases
- Ensure medical support staff completes required documentation
Radiation Oncology Measure Specifications
# Radiation Oncology Measure Specifications

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer</td>
<td>Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period</td>
</tr>
<tr>
<td>72</td>
<td>Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patient</td>
<td>Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period</td>
</tr>
<tr>
<td>102</td>
<td>Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer</td>
</tr>
<tr>
<td>104</td>
<td>Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients</td>
<td>Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)</td>
</tr>
<tr>
<td>Measure Number</td>
<td>Title</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>110</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration</td>
</tr>
<tr>
<td>143</td>
<td>Oncology: Medical and Radiation – Pain Intensity Quantified</td>
<td>Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified</td>
</tr>
<tr>
<td>144</td>
<td>Oncology: Medical and Radiation – Plan of Care for Pain</td>
<td>Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain</td>
</tr>
</tbody>
</table>
# Radiation Oncology Measure Specifications

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>156</td>
<td>Oncology: Radiation Dose Limits to Normal Tissues</td>
<td>Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues</td>
</tr>
<tr>
<td>194</td>
<td>Oncology: Cancer Stage Documented</td>
<td>Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once within 12 months</td>
</tr>
<tr>
<td>226</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
</tr>
</tbody>
</table>
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security
  Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

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

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

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

• What is Fair Warning?
• **Fair Warning** is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
• **Fair Warning** protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.
• **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA auditing.
• UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: [http://www.med.miami.edu/hipaa](http://www.med.miami.edu/hipaa)
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