Compliance Compass

Vanderbilt University Medical Center Office of Compliance and Corporate Integrity

July 2010
Table of Contents

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For a copy of our Newsletter you can download it from our website or contact us by telephone.

Dr. Ossoff Appointed to HCCA's CHC Item Writing Committee

Dr. Robert H. Ossoff, Assistant Vice Chancellor of the Office of Compliance and Corporate Integrity, was recently selected as a member of the CHC (Compliance in Health Care) Item Writing Committee of the Health Care Compliance Association (HCCA). This committee is charged with writing and reviewing questions that comprise for the CHC examination. Those who take this examination are candidates to be certificate in health care compliance.

Dr. Ossoff successfully completed this process last year and is among those certified in VUMC Office of Compliance and Corporate Integrity. He has been active in the HCCA and it is certainly an honor that he was considered from among numerous compliance professionals.

Our staff is pleased that through Dr. Ossoff's appointment, Vanderbilt is again recognized as a leader in health care compliance.

VUMC Holds New Faculty Orientation

Submitted by Julie Appleton

With the arrival of new residents and faculty on campus beginning July 1st , the Office of Faculty Affairs hosted its mid-year faculty training session on July 8th. Joining several other departments, the Office of Compliance and Corporate Integrity (OCCI) played a role in providing information that will be vital to the more than 80 new additions to our community.

Assistant Vice Chancellor Robert Ossoff presented to new faculty an introduction to the basics of compliance pertaining to rules and regulations. His overview included a glimpse of why the OCCI exists, the importance of having a compliance office, and the responsibilities and function of Vanderbilt Medical Center's Compliance Office

Julie Appleton, Compliance Manager, discussed the basics of evaluation and management coding. Her presentation also included a brief overview of some policies regarding general medical record documentation.

The Compliance Office encourages you to read the newsletter. Embedded in some of the articles is an employee ID #. If you locate it, contact Fernando Murphy at 3-7266, noting which article your ID # appears in to receive your gift.

During this one-day session, information disseminated to attendees by the Office of Faculty Affairs and the Compliance Office insures our new residents and faculty have a basic understanding of policies and regulations that govern the medical center. Time allocated to each presenter is definitely well received.

It is essential that all new faculty attend compliance training within 90 days of their start date; however, it is not necessary to wait for one of the bi-annual sessions to attend. The OCCI holds monthly compliance training sessions for new faculty on the third Tuesday of each month. New faculty who need this training are encouraged to sign up online at http://www.mc.vanderbilt.edu/root/vumc.php?site=DCCI&doc=26773

Medicare Modifiers GA and GX

Submitted by Darija Giniunaite

Effective April 1, 2010, Medicare updated two modifiers GA and GX in order to distinguish between voluntary and required uses of liability notices.

Modifier **GA** has been redefined to mean that a "waiver of liability statement has been issued as **required** by payer policy" and patient is liable. MC will assign beneficiary liability to claims automatically denied when the GA modifier is present (claim adjustment reason code 50; these are non-covered services because this is not deemed a "medical necessity" by the payer).

New modifier **GX** became effective April 1, 2010. This modifier has been defined as: "notice of liability issued, voluntary under payer policy". This modifier is reported when a **voluntary** ABN is issued for a non-covered service. Medicare will return your claim if the GX modifier is used on any line reporting covered charges. Modifier GX may be reported for services formerly reported with the Notice of Exclusion from Medicare Benefits (NEMB) form. This form has been discontinued by CMS and should no longer be used to report non-covered or excluded services.
GX may be used with modifier GY or TS (follow up services) or other liability-related modifiers. 0095554
Medicare will automatically deny lines (claim adjustment reason code 50), with assigned beneficiary liability to claims when the GX modifier is present.

Medicare will return claim with GX modifier if used along with GA, GZ and some other liability-related modifiers.

Additional information on reporting these modifiers may be found on the CMS website at URL:
http://www.cms.gov/MLNMattersArticles/downloads/MM6563.pdf

Fifth Time a Charm

The Federal Trade Commission Delays Red Flag Rules Again

Submitted by Tawanda Maxell

In a May 28 press release the Federal Trade Commission (FTC) announced that they are again delaying the implementation deadline for the Red Flag Rules to December 31, 2010.

This recent delay is the fifth since 2008. The original compliance deadline was November 1, 2008 but it was delayed until May 1, 2009, then again to August 1, 2009, November 1, 2009 then to June 1, 2010 and now until December 31, 2010. The reason for each of these delays has varied from providers not knowing that they were subject to the rules of the Red Flag Rules, to allowing creditors and financial institutions more time to develop and implement their identity theft prevention programs, to Congress asking for a delay due to a bill (H. R. 3763) that passed the House of Representatives unanimously on October 20, 2009.

This bill states that businesses – including physicians – with 20 or fewer employees wouldn't be subject to the Red Flag Rules. The bill would also allow certain businesses

to apply to the FTC for an exemption if the business could prove that they know all their customers or clients personally, only perform services in or around the residences of its customers, or has not experienced incidents of identity theft and identity theft is rare for a business of that type.

This most recent delay is also at the request of Congress because it is still working on legislation to limit the scope of the Red Flag Rules. The FTC stated that "a limited further postponement is warranted so that it does not begin to enforce a regulation that Congress plans to supersede." The FTC further stated that if Congress passes a law with an earlier effective date the FTC will start enforcement before the end of the year.

The Red Flag Rules are a result of the Fair & Accurate Credit Transaction Act of 2003 (FACTA). These rules focus on the prevention of identity theft. Originally intended for financial institutions and creditors, the Red Flag Rules became applicable to healthcare entities because they are considered creditors.

In effect since January 1, 2008, the Red Flag Rules requires businesses and organizations to implement a written Identity Theft Prevention Program designed to detect the warning signs – red flags – of identity theft in their day to day operations, take steps to prevent identity theft and mitigate the damage it inflicts.

Appropriate Authentication

Submitted by Joy Carr

The new scrutiny regarding signature requirements is a hot topic of discussion these days. In a recent CMS newsletter MLN Matters, Signature Guidelines for Medical Review Purposes – JA6698, CMS attempts to clarify how providers can ensure they meet the signature requirements Medicare review contractors follow. This is a technical issue that outside reviewers can easily focus on, because if the requirements are not met the claim is subject to technical denial. Technical denials are easier to define and enforce than arguing medical necessity of the service, thus a denial by a government contractor for a technical reason is a cheaper, more efficient use of their staff resources and results in less overturn rates on claim appeals. 0095643

Providers can authenticate their documentation by using a written or electronic signature. However, it is never appropriate to use a signature stamp.

ACs (Affiliated Contractors), MACs (Medicare Administrative Contractors), PSCs (Program Safeguard Contractors), ZPICs (Zone Program Integrity Contractors), and CERTs (Comprehensive Error Rate Testing Contractors) will be looking for the following in regards to handwritten signatures:

- **Illegibility** – The reviewer has the choice of whether or not a signature log or attestation statement will be allowed to confirm the identity of the provider.
- **Orders with Missing Signatures** – The order will be disregarded by the reviewer.
- **Other Medical Documentation with Missing Signatures** – The reviewer will consider accepting a signature attestation which must be from the author of the documentation.

On page 12 of the following link, ***http://www.cms.gov/Transmittals/downloads/R327PI.pdf*** , you will see a list of sixteen scenarios and whether or not those scenarios meet the handwritten signature requirements or require follow up attestations.

In regards to electronic signatures, the system in place needs to ensure documentation by a provider does not allow change once it is authenticated. Addendums and attestations that allow separate signatures are acceptable. A reviewer may ask about the security of the electronic medical record in order to prove documents cannot be altered after completion.

In addition the Conditions of Participation located at 42 CFR 482.24(c)(1)(i) states, "All entries in the medical record must be dated, timed, and authenticated, in written or

electronic form, by the person responsible for providing or evaluating the service provided."

Vanderbilt policies related to authentication can be found at the links below:

https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/77CA5B89B9CD7BBE86256BE40066EC09

https://mcapps.mc.vanderbilt.edu/E-Manual/Hpolicy.nsf/AllDocs/CC3EF13404510E2C86256BE3006A2B96

CMS Puts Off Date-of-Service Rule Changes Until July

Submitted by Deborah Johnson

The new rules from the Centers for Medicare and Medicaid Services (CMS) that could force health care providers to follow two separate rules for assigning the date of service (DOS) — one for Medicare and one for all other payors — won't take effect until July 1, 2010 according to Transmittal 1873, dated Oct. 2.

According to the transmittal, the appropriate professional component DOS should be the actual calendar date that the interpretation was performed. Therefore, if a radiologist provides the interpretation (professional component) for an x-ray performed at the hospital (or other facility) where the radiologist cannot report the global service, she should report the DOS as the date she actually issued the interpretation rather than the date of the technical service (the day on which the x-ray was taken), based on the CMS guidance.

So what happens when a non-Medicare payor rejects a professional component claim if the DOS does not match that for the technical component? The new DOS reporting requirement may prove challenging, and it is anticipated that providers may have two separate rules for assigning DOS — one for Medicare and one for other payors.

Physician Supervision of Diagnostic Tests

Submitted by Deborah Johnson

The Centers for Medicare and Medicaid Services (CMS) requires that physicians supervise diagnostic tests, but the level of supervision depends on the nature of the test. Plus, CMS defines the supervision levels differently for physician practices and hospitals.

The Medicare Benefit Policy Manual (Chapter 15, §80) defines the following three levels of physician supervision for diagnostic tests:

- **General Supervision** means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.
- **Direct Supervision (**in the office setting) means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The physician does not have to be present in the room when the procedure is performed.
- **Personal Supervision** means a physician must be in attendance in the room during the performance of the procedure.

For general supervision of diagnostic tests in the hospital setting, the hospital (not the physician) is responsible for the training, maintenance and supplies. The Medicare Benefit Policy Manual (Chapter 6, §20.4.4) states, "Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the facility."

The Medicare Physician Fee Schedule (MPFS) contains a physician supervision indicator for each diagnostic test CPT® or HCPCS code:
• 1 — general supervision
• 2 — direct supervision
• 3 — personal supervision

The supervision requirement applies to the technical component of the test (the facility service) rather than to the professional component (interpretation). But if the technical component of the test does not comply with the supervision requirements, then you cannot bill the test interpretation either. Only a physician (MD or DO) can provide the required level of supervision. CMS has stated that a non-physician practitioner cannot provide physician supervision of diagnostic tests.

Hospital Supervision Required, Too

The Outpatient Prospective Payment System (OPPS) Final Rule for 2010 clarified that hospitals must follow the same physician supervision rules for their outpatient tests. It reads, "All hospital outpatient diagnostic services provided directly or under arrangement, whether provided in the hospital, in a [provider-based department (PBD)] of a hospital, or at a nonhospital location, follow the physician supervision requirements for individual tests as listed in the MPFS Relative Value File."

In addition, CMS issued the following special criteria in the 2010 Final Rule for physician presence during a hospital outpatient exam that requires *direct* physician supervision:

• When the exam is performed in the hospital or in an on-campus outpatient department (PBD), the supervising physician "must be present on the same campus." The physician may be located anywhere on the campus, including a physician's office, an on-campus skilled nursing facility or other nonhospital space.
• When the exam is performed in an off-campus outpatient department (PBD), the supervising physician "must be present in the off-campus PBD."
• When the exam is performed under arrangements in a nonhospital location such as a physician office, the supervising physician must be "present in the office suite."

According to the CMS 2010 OPPS Final Rule, during a procedure that requires direct supervision, the physician must be "immediately available to furnish assistance and direction throughout the performance of the procedure," This means the physician must not be performing another procedure that cannot be interrupted and must not be so physically far away that he/she could not provide timely assistance.

What Is a Compliance Program

By Deborah Johnson

The OCCI recently celebrated Corporate Compliance & Ethics Week and during our day of activities in the TVC courtyard, employees asked significant questions concerning VUMC's Compliance Program. So we thought this issue of the *Compass* would be a great place to post some answers. Let's start with the question of "What is a Compliance Program?"

> A Compliance Program is an organizational effort to (1) prevent, identify and correct instances of conduct that do not conform to Federal and state laws and regulations, and health care program requirements and (2) to guide a hospital's governing body, CEO, managers and other employees, independent contractors, medical staff and other health care professionals in the efficient management and operation of the hospital.

The importance of having a Compliance Program lies it its ability to reduce fraud, abuse and waste for health care programs, which reduces an enterprise's exposure to civil and criminal penalties and reduce overall costs of providing health care. Our Compliance Program not only furthers the mission to provide quality health care to patients, but also reflects VUMC's

commitment to achieve compliance standards established by the United States Sentencing Commission Guidelines ("Sentencing Guidelines") and the U.S. Department of Health and Human Services, Office of Inspector General's ("OIG's") Compliance Program Guidance. Additionally, it increases the likelihood of preventing, identifying and correcting unlawful or unethical behavior at an early stage; reinforces the enterprise's commitment to honest and responsible corporate conduct, and encourages employees to report potential problems to allow for internal inquiry and corrective action

Another question asked was, "Is it mandatory that Vanderbilt implement a Compliance Program?" The answer is both yes and no. No, it is not a law per se. However it cannot be ignored in today's regulatory enforcement environment. When the OIG visits an organization, having an effective Compliance Program can and will impact decisions and outcomes.

VMC has taken several steps to implement a Compliance Program, structuring their program based on the OIG's 7 core principles. 0091620 These core principles are:

1) implement written policies, procedures, and standards of conduct;
2) designate a compliance officer;
3) conduct effective training;
4) develop effective lines of communication;
5) enforce standards through well-publicized disciplinary guidelines;
6) conduct internal monitoring and auditing; and
7) respond promptly to detected offenses, developing corrective action and
reporting to the government.

While many of you are familiar with our auditing and training modules, the relationship OCCI has with the VUMC campus is inclusive and widespread. Everyone who works in healthcare will be subject to Regulations and Guidelines that speak to Compliance - from the employees in the cafeteria to housekeeping, administrative to clinical, from operations to health services, everyone is impacted. Therefore, the more supervisors, managers, directors, and chancellors know about the significance of having a robust program and the role they play in implementing the program at a organizational, departmental, and personal level, the better equipped we all will be to recognize potential risks. Each of us need to be equipped with the knowledge of how to prevent, identify and correct instances of conduct that do not conform to Federal and state laws and regulations and healthcare program requirements.

To have an effective Compliance Program will require the promotion of a culture of detection and prevention, and that responsibility belongs to each of us.

Appropriate Authentication

Submitted by Deborah Johnson

Q. Would it be acceptable to order tests on patients during preadmission testing based on the patient's history without an order from a physician?

A. It is not acceptable for the laboratory to perform any testing without a physician's order or to use a patient's history as the reason for testing. Laboratory tests can only be performed when there is a written request from an "authorized person," a licensed health professional performing within the scope of his or her state license. This is a CLIA regulation. Providers who order tests must provide the laboratory with the reason for testing at the time the test is ordered.

Compliance violations can occur anywhere at any time. A violation can be intentional or unintentional. The environment that we work in is very complex and so are the laws that govern our industry. A simple explanation of a compliance violation is any action that has caused Vanderbilt to non-comply with a law, rule, regulation, policy or procedure. You always have the right to report a potential violation directly to the Compliance office with the VMC confidential compliance hotline.

Medical Center Compliance Confidential Hotline
615-343-0135

Submit any questions or comments to:
Compliance.office@vanderbilt.edu

Did You Know

Submitted by Joyce Will

Did you know that the incorrect POS code could affect the Medicare payment for a specific service?
That means we need to be aware of the most frequently used POS codes. Here is a list of the ones Vanderbilt will use most often:

• **11 — Office.** Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis. You should use this POS code for services performed in the physician's office or in an independent diagnostic testing facility (IDTF).
• **21 — Inpatient Hospital.** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
• **22 — Outpatient Hospital.** A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons
who do not require hospitalization or institutionalization.
• **23 — Emergency Room – Hospital.** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
• **24 — Ambulatory Surgical Center.** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
• **31 — Skilled Nursing Facility.** A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital..

Tawanda Maxwell Joins the OCCI Team

The Office of Compliance and Corporate Integrity welcomed Tawanda Maxwell, Coding Compliance Consultant, as she joins our compliance team. Tawanda started her healthcare career at Vanderbilt in 2000 as an Adult/Pediatric Emergency Department Registration Specialist. She then moved to the Department of Finance as a Patient Representative. Before joining the OCCI she worked as an Account Reimbursement Specialist, specializing in Medicare appeals and billing. The entire OCCI group welcomes Tawanda to our family.

OCCI Employee Spotlight:

Darija Giniunaite

Coding Compliance Consultant

Darija attained her Certified Professional Coder (CPC) credential through the American Academy of Professional Coders. She has a Bachelor's Degree in Chemistry and Biology. Darija has worked in the healthcare industry since the year 2000. She joined VUMC in 2005 and the Office of Compliance and Corporate Integrity in 2006.

In my spare time I like to: Spend time outside, go to the park, hike or just pick fruit on the farm.

My favorite pastime or hobby is: Reading and enjoying my husband's cooking.

The favorite aspect of my job here at VMC is: The healthy balance of desk work and meeting numerous providers and staff members across the VMC community.

Calendar of Events

HCCA HEALTH CARE COMPLIANCE ASSOCIATION

South Central Regional Conference
November 12, 2010
Willis Conference Center
26 Century Blvd
Nashville, TN 37214

Dr. Robert Ossoff, Assistant Vice-Chancellor for Compliance & Corporate Integrity will deliver the presentation, "***Pointers and Pitfalls in Gaining Physician Buy-in to a Compliance Program"***

VUMC to Host THA's Fall Conference

THA TENNESSEE HOSPITAL ASSOCIATION

The VUMC Office of Compliance and Corporate Integrity will again play host to the Tennessee Hospital Association's Fall Conference at the Student Life Center on October 1, 2010. At the request of THA and in consideration of the partnership with Vanderbilt Medical Center, the OCCI accepted the invitation to host the event last year. As a result of the excellent feedback from attendees of various healthcare and governmental agency participants, we were requested to co-sponsor this valuable conference again this year.

Featured speakers will include Robb Miller (CMS), Curtis Watkins (AdvanceMed Corp.), Sara Kay Wheeler (King & Spalding), Dr. Greg Mckinney (CAHABA) and other highly recognized professionals from local, regional and national corporations and agencies that specialize in health care compliance, policies, and regulations.

Information pertaining to registration and attendance can be found at:
http://www.tha.com/