Review of HIPAA Compliance

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Agenda

- The Importance of Audits
- Compliance and Regulatory Guidelines
  - Federal Regulations
  - Office of Inspector General (OIG)
  - Medicare and Medicaid (CMS)
- Medical Record Standards and Documentation Guidelines
  - HIPAA
- Guidance on Telehealth and HIPAA During COVID 19
- Evaluation and Management Guidelines (E/M)
- The Audit Process Overview
- Managing Risk
  - Communicating the Audit Findings
  - Continued Provider Communication

The Importance of Audits

- Medical auditing is critical to a complaint and profitable practice
- Medical audits can provide the following:
  - Understanding the quality of care provided to patients
  - Address areas of education opportunity to providers regarding documentation guidelines
  - Ensure all services are supported by medical necessity and appropriate diagnosis are captured
  - Help to better manage revenue capture
  - Defends against external audits, malpractice, and billing denials
- A successful audit supports the provider and helps to reduce potential risk areas
  - Misusing codes
  - Billing for services that are not medically necessary
  - Failing to maintain adequate medical or financial records
  - Improper billing practices

Compliance and Regulatory Guidelines

- Overview of Federal Regulations: Federal departments monitor fraud, abuse, and compliance including the federal False Claims Act (FCA), Civil Monetary Penalties Law (CMPL), Physicians Self-Referral law, and Anti –Kickback Statute.
- **OIG:** To help healthcare providers such as hospitals and physicians comply with relevant Federal health care laws and regulations, OIG creates compliance resources, which are often tailored to particular providers. OIG's compliance documents include special fraud alerts, advisory bulletins, podcasts, videos, brochures, and papers providing guidance on compliance with Federal health care program standards.
  - The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections.
  - Compliance Plans represent comprehensive documentation that a provider, practice, facility, or other healthcare entities are taking steps to adhere to federal and state laws.
- **CMS:** The Healthcare Financing Administration (HCFA) was established in 1977 to administer the Medicare and Medicaid programs. Renamed the Centers for Medicare & Medicaid Services (CMS) in 2001, it is the largest agency within the Department of Health and Human Services (HHS). CMS helps to drive new or changed policies and procedures.
  - CMS 5 practical tips for creating a culture of compliance:
    - Make compliance plans a priority
    - Know your fraud and abuse risk areas
    - Manage you financial relationships
    - Don’t follow competitors
    - When in doubt ask for help and/or support

Medical Records Standards

- HIPAA was enacted on August 21, 1996 to provide rights and protections for participants and beneficiaries of group health plans. HIPAA also established the Healthcare Fraud and Abuse Control Program, a program designed to combat fraud and abuse in healthcare, which includes both public and private health plans.
- Privacy Rule standards address how and individual's protected health information (PHI) may be used. Its purpose is to protect individual privacy. Covered entities are defined as health plans, healthcare clearinghouses, and any healthcare provider who transmits health information in an electronic format.
- Minimum Necessary standard is a key protection of HIPAA Privacy Rule. The Privacy Rule requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. **Example:** PHI may be used by a covered entity for treatment, payment, and healthcare operational activities.

Documentation Guidelines

CMS provides guidelines to help ensure every patient's health record contains quality documentation. General principles of medical record documentation for reporting medical and surgical services for Insurance payment include (when applicable to the specific setting/encounter):

- Medical records should be complete and legible
- Documentation of each patient encounter should include:
  - The reason for the encounter and relevant history;
    - Physical examination findings and prior diagnostic test results;
    - Assessment, clinical impression, and diagnosis;
    - Plan of care; and
    - Date and legible identity of provider/clinical staff
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician Appropriate health risk factors should be identified
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented
- CPT and ICD-10-CM codes reported on claim form should be supported by documentation in the medical record

Telehealth HIPAA Compliant Vendor

Having a HIPAA compliant patient platform will support HIPAA compliance while ensuring patient privacy is not being violated. PHI is “individually identifiable health information” such as demographic data, name, address, birth date, and Social Security number.

- Hale Health (NEPHO Telehealth Pilot Program Vendor): https://www.hale.co/
- Doxy.me: https://doxy.me/ (many of our practices are having success with Doxy me)
- AllWays Health Partners: Microsoft TEAMS (Free): https://allwayshealthpartners.org
- Zoom for Healthcare (plans start at $200/month): https://zoom.us/healthcare
- EPIC Users:
  - EPIC Community Connect: Contact Lesley Bailey @ 781-744-9664 and/or lesley.bailey@lahey.org
  - Lahey EPIC: Contact Lahey EPIC IT Department to discuss options: http://inside.lahey.org/ehr/epic/telehealth/

Telehealth Patient Consent Form

- Add verbiage in existing patient consent form or create and additional patient consent form specific to Telehealth services that outline the guidelines put in place at the practice level
  - What is Telehealth
  - Telehealth Practice Policy (example: non payment excludes them from the ability to be seen via Telehealth, scope of services allowed to be conducted by Telehealth and number of Telehealth visits that can be conducted before an in person visit is required)
  - Telehealth vendor being used is HIPAA compliant
  - Responsibility for and co-payment or coinsurance that apply to the Telehealth visit and if the insurance does not cover the services that the patients understands responsibility of such costs
  - Self pay option statement and cost
  - Right to withhold or withdraw consent in the course of care at anytime during the telehealth visit

Telehealth Malpractice Insurance Coverage

Telehealth and medical malpractice is uncharted territory. It is theoretically possible to file a claim under various scenarios of medical negligence such as incorrect interpretation of data, miscommunication or failure to communicate, inadequate monitoring, and incorrect or incomplete treatment. While the legal implications of telehealth remain complex, there is a need to work directly with your malpractice insurance broker as Telehealth moves forward into the future.

- States have adopted standards of medical care that are different from the national standards. The inconsistent clinical guidelines for Telehealth have opened the door to potential practice risk.
- Malpractice claims involving Telehealth are currently small. The decision to file a lawsuit for medical negligence is not an easy one, and when Telehealth is involved, it can get even more complicated. During this timeframe Telehealth lawsuits are limited.
- Contact your malpractice carrier to see if you need to update your malpractice policy to include language to better cover Telehealth services.

Review E/M Guidelines

- In late 1994, CMS published the Documentation Guidelines for E/M services to help give direction on how to quantify each level of service, the type of service, and what documentation was needed for each key component.
- In 1997 CMS updated the E/M guidelines for exams. A provider can choose from either 1995 or 1997 guidelines for documentation supporting exams.
- An E/M visit consists of 3 components:
  - History: Chief complaint, history of present illness, review of systems, past family, social history
  - Exam
  - Medical Decision Making (MDM)
- The levels of E/M services are based on four types of examinations:
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive
- New E/M changes are coming January 1, 2021

The Audit Process

The decision to conduct an audit can be based on a request within the practice or because the practice compliance plan required an annual audit. Careful consideration should be given to who will be audited, what services will be audited, and how the audit will be performed.

- Types of Audits
  - Internal versus External
  - Focused versus Random Audits
  - Prospective versus Retrospective Audits
  - Peer Review
  - Aggregate Analysis
- Steps in Audit Process
  - Determine the scope
  - Determine sample selection
  - Know the tools and resources needed to conduct the audit
  - Collect data/documentation
  - Complete the audit – Report results

Better Management of Risk

- Audits help to avoid potential risk areas within a practice
- Audits help to address areas of missed documentation and/or diagnosis opportunity
- Voluntary Re-Payment Audits – over payments are discovered and need to disclosed and refunded to the payers
- Correction Action Plans help support providers in addressing areas of concern/risk
- Development/Modification of Practice Policies will help avoid future errors
- Follow-up Audits
- Have an Internal Audit Plan in place
- Review the Cost for an Annual External Auditor
- Document all External/Internal Auditing Practices

Communicating the Audit Results

- Audits will identify areas of education focus:
  - Documentation,
  - Coding (CPT, ICD-10 CM, HCPCS)
  - Billing policies
- Components of an Audit Report
  - Audit Objective
  - Type of Audit
  - Audit Scope
  - Summary of Audit Findings
  - Include detail to resources to support audit findings
- Speaking Directly to Providers
  - Offer recommendations to avoid future errors
  - Focus on solution rather than problem
  - Help implement a plan of action

Continued Communication

- Provide a follow-up audit to support plan of action
- Keep providers, clinical staff, coding and billing updated on coding changes and updates
- Offer continued coding and billing education through online and in person training
- NCCI updates quarterly
- CPT updates annually on January 1st
- ICD-10 CM updates annually on October 1st
- Have an understanding of the OIG work plan
- Stay current on payer policies and update providers
- Onboard new providers – audits, education, practice policies

Resources

- https://www.aapc.com/
- http://www.ahima.org/
- https://www.cms.gov/
- https://www.beckerjustice.com/blog/2016/october/telemedicine-and-medical-malpractice/
- https://www.aapc.com/discuss/#auditing.605
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