Weill Cornell Medicine

General Compliance & Physician At Teaching Hospital (PATH) Lecture

Office of Compliance

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Office of Compliance

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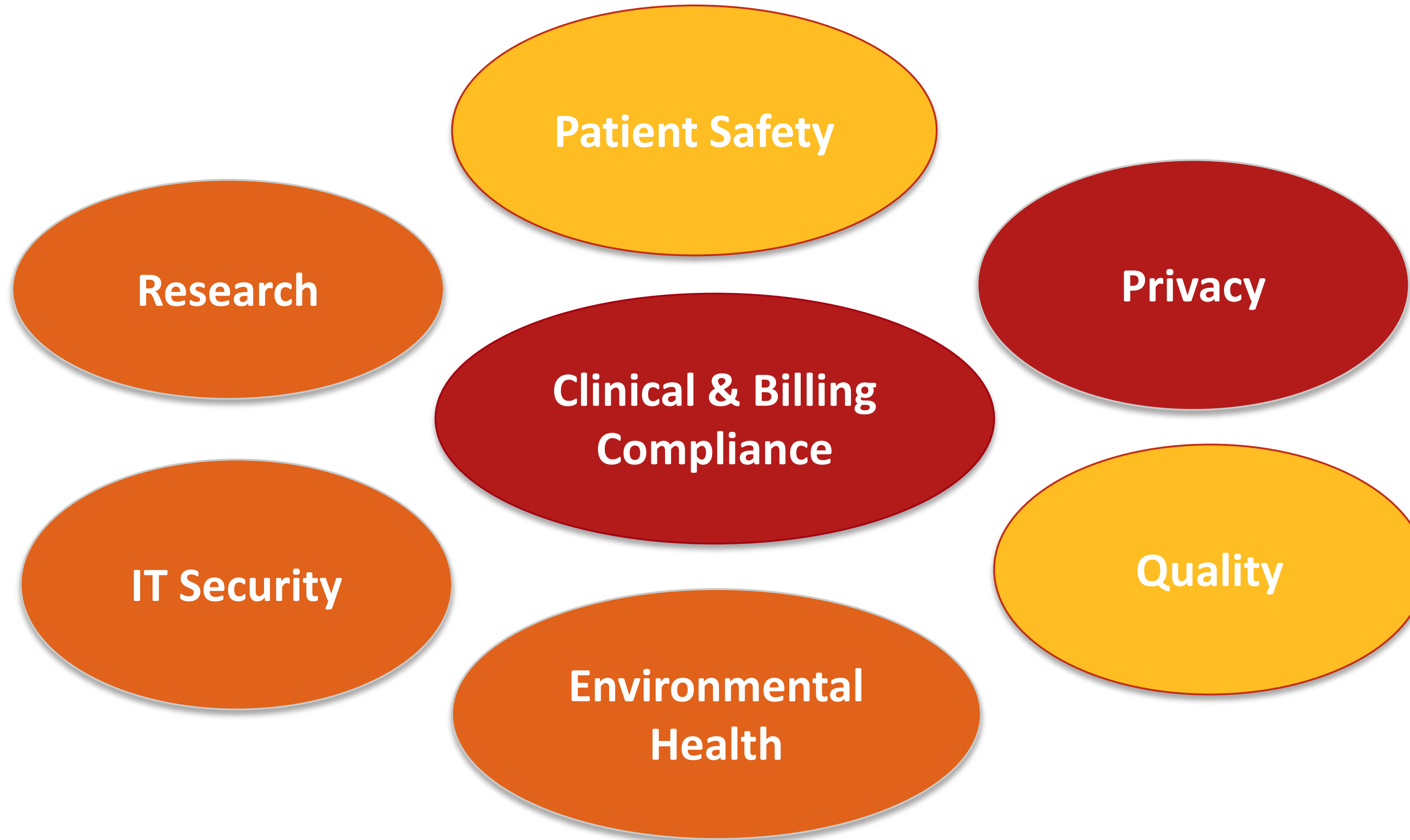
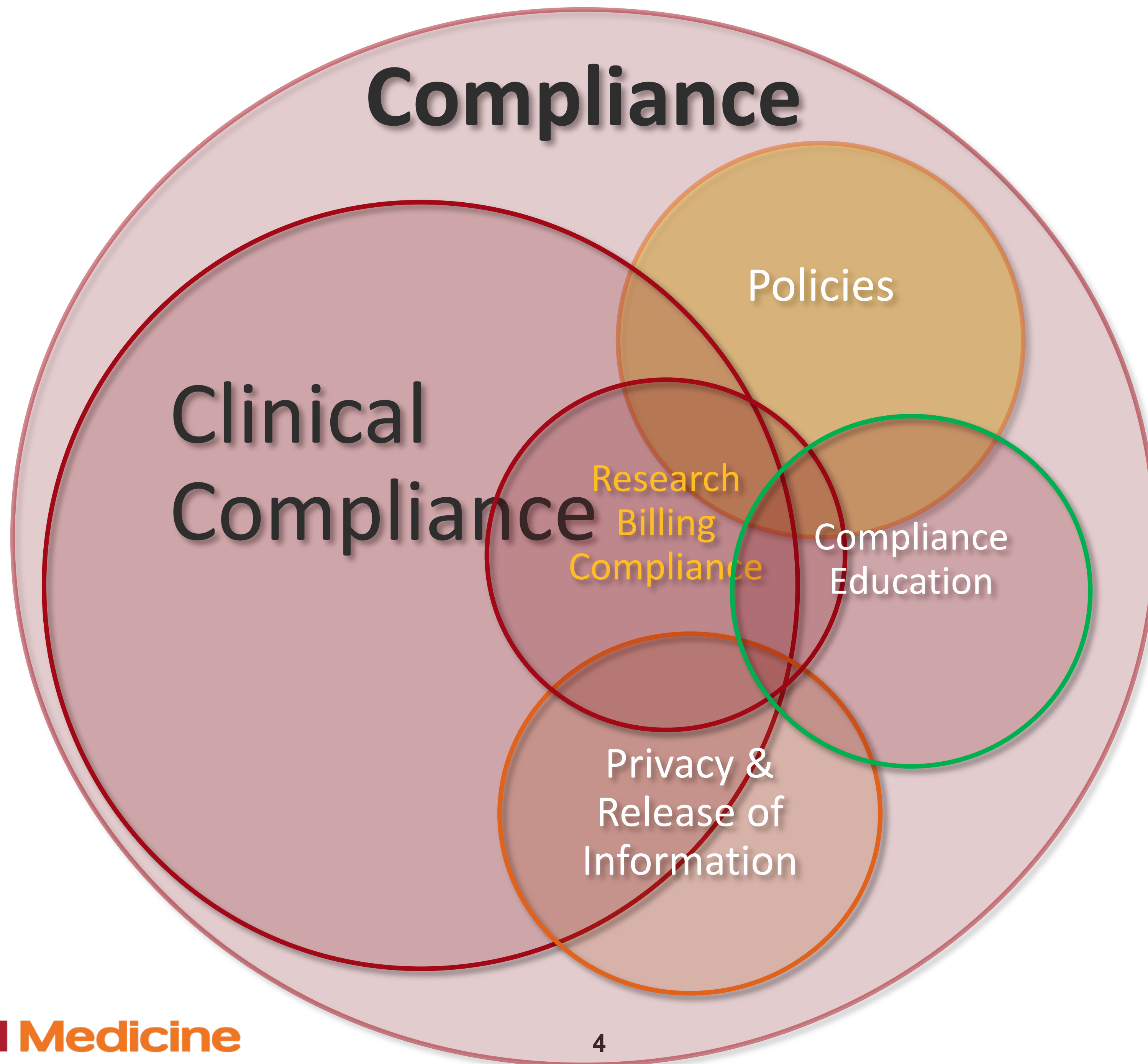
CONTACT US!

Today's Focus: **Clinical & Billing Compliance** and **Privacy**





Weill Cornell Medicine

What is expected of an “*effective*” Compliance Program?

‘Well-integrated operations’

‘appropriate standing, authority and independence’

‘Supported by the highest levels of the organization, including the CEO, senior management, and the governing body.’

‘Reasonably designed to *prevent*, *detect*, and *correct* non-compliance, considering the provider’s specific risk areas and organizational experience.’

OIG Core Elements & WCM Plan

OIG Core Elements

Weill Cornell Plan

WCM Compliance Program

- Support the integrity of the practice's mission:
  - Institutional reputation
  - Ability to preserve resources
  - Do the right thing
- Industry standard—Required by law
  - Federal Sentencing Guidelines
  - OIG Guidance
  - False Claims Act
  - Deficit Reduction Act
  - Fraud Enforcement and Recovery Act of 2009

What is Clinical and Billing Billing Compliance?

WCM Clinical Compliance Oversight Committee and the Weill Cornell Medicine Office of Compliance are responsible for promoting faculty and practice adherence to regulations regarding medical record ***documentation***, ***coding***, ***billing*** and ***reimbursement***.

WCM's compliance program is designed to ***prevent*** and ***detect*** billing errors that might lead to a fraud and abuse investigation and possible exclusion from federal programs.

Range of Compliance Oversight

- Clinical Compliance
  - Centralized Audit Services [Internal Staff, External Vendors]
  - Non-Coding Audits [Internal Process]
    - Documentation requirements
    - False Claims
    - Fraud, Waste and Abuse
    - Anti-Kickback & Stark Laws
    - GME supervision
    - Overlapping Surgeries
- Regulatory Compliance
  - Education, Training, Policies & Procedures, Guidance, Inquires
  - Exclusion Screening Monitoring
  - Investigations
- Research Billing Compliance
  - Audit Services, Reporting, Policies & Procedures, Guidance, Inquiries
- Clinical Documentation Improvement (ACO)
  - Documentation Analysis, Performance Monitoring, Provider Education
- Other Responsibilities under the Office of Compliance
  - Auditing for Policy Compliance – e.g., Chaperone Policy
  - Lead role in investigations – e.g., recent case that involved not only billing compliance, but also surprise billing, trainee supervision, and quality of care.

Regulatory Guidelines

New York Medicaid Integrity Program

In 2023, the New York State Office of the Medicaid Inspector General (OMIG) achieved over $4 billion in cost savings and recoveries. This included addressing inappropriate payments and ensuring compliance with Medicaid regulations.

- Received 3,666 allegations of Medicaid fraud, waste and abuse.
- Completed 2,022 investigations.

Home | About Fraud | Protect Yourself | HEAT Task Force Success | In the News

How to Spot Fraud

Be suspicious of doctors, health care providers, or suppliers that tell you the following:

- The equipment or service is free; it won't cost you anything, and they only need your Medicare number for their records
- Medicare wants you to have the item or service.
- They know how to get Medicare to pay for the item or service.
- The more tests they provide, the cheaper the tests become.

Protect Yourself from Fraud

Learn how to protect yourself from fraud and identity theft and private companies.
More >

Be suspicious of doctors or plans that do the following:

- Don't charge copayments without checking on your ability to pay
- Advertise "free" consultations to people with Medicare
- Claim they represent Medicare or a branch of the Federal government
- Use pressure or scare tactics to sell you high-priced medical services or diagnostic tests
- Bill Medicare for services you didn't get
- Use telephone calls and door-to-door selling as marketing tools
- Offer non-medical transportation or housekeeping as Medicare-approved services
- Put the wrong diagnosis on the claim so that Medicare will pay
- Bill home health services for patients who aren't confined to their home, or for Medicare patients who still drive a car
- Bill Medicare for medical equipment for people in nursing homes
- Ask you to contact your doctor and ask for a service or supplies that you don't need
- Bill Medicare for tests you received as a hospital inpatient or within 72 hours of admission or discharge
- Bill Medicare for a power wheelchair or scooter when you don't meet Medicare's qualifications

Examples of Medicaid Fraud:

- Billing for medical services not actually performed.
- Providing unnecessary services.
- Billing for more expensive services.
- Billing for services separately that should legitimately be one billing.
- Billing more than once for the same medical service.
- Dispensing generic drugs but billing for brand-name drugs.
- Giving or accepting something of value (cash, gifts, services) in return for medical services, i. e., kickbacks.
- Falsifying cost reports.

Or when someone:

- Lies about their eligibility
- Lies about their medical condition
- Forges prescriptions
- Loans their Medicaid card to others

Or when a health care provider falsely charges for:

- Missed appointments
- Unnecessary medical tests
- Telephoned services

If you suspect fraud or abuse, call:

1-877-87-FRAUD (1-877-873-7283)

Toll Free

• State of New York •
• Office of the Medicaid Inspector General •
www.omig.state.ny.us

Key Compliance Risks: Fraud, Waste, Abuse & Exclusion

Term	Definition	Key Point
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.	*Intentional deception* for financial gain.
Waste	Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicare Program, such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.	*Misuse of resources*; not usually intentional or criminal.
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.	*Improper practices* without intent to defraud.
Exclusion	No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the OIG. The OIG has authority to exclude individuals and entities from federally funded health care programs and maintains the List of Excluded Individuals and Entities (LEIE).	Check OIG **LEIE** before engaging providers/entities.

Filing False Claims: Understanding the Risk and Penalties

The False Claims Act (FCA) is a federal law that imposes liability on individuals and companies who defraud governmental programs.

- Knowingly submitting false or fraudulent claims for payment to the government is illegal.
- Any person who files a claim with misrepresentation, false, incomplete, or misleading information may be committing a criminal act.
- Such actions are punishable under the law and may result in civil penalties, including fines and damages.

Your Name Goes Here

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CMS-1500 Form

Stark Law and Anti-Kickback Statute

Stark Law (42 USC § 1395nn)

The Stark Law applies to Medicare and Medicaid programs. The Stark Law **prohibits physicians from referring Medicare patients** for designated health services to an entity with which they or their immediate family members **have a financial relationship** unless an exception applies. Additionally, the law prohibits the entity from submitting claims to Medicare for services resulting from a prohibited referral. This law applies explicitly to referrals made by physicians. It focuses on designated health services, such as lab tests, imaging, and other specified services.

Intent: There is no intent standard for overpayment, meaning strict liability applies. However, intent is required for civil monetary penalties in cases of knowing violations.

Penalties: Violations of the Stark Law can result in civil penalties, including fines and exclusion from Medicare and Medicaid programs.

Exceptions: To prevent violations, mandatory exceptions, such as the in-office ancillary services exception, must be met to avoid violations. The Stark Law applies to Medicare and Medicaid programs.

Anti-Kickback Statute (42 USC § 1320a-7b(b))

The Anti-Kickback Statute applies to all Federal healthcare programs, including Medicare and Medicaid.

The Anti-Kickback **Statute prohibits offering, paying, soliciting, or receiving anything of value** to induce or reward referrals or generate business for Federal Health Care programs. This statute applies to referrals from anyone, not just physicians. It covers any items or services, not limited to designated health services.

Intent: Intent must be proven for criminal and civil/administrative penalties, meaning the actions must be knowing and willful.

Penalties: Violations of the Anti-Kickback statute can result in criminal and civil/administrative penalties, including fines and imprisonment.

Exceptions: Some voluntary safe harbors protect from liability if certain conditions are met, such as properly structured joint ventures and discounts.

In the News!!!

DOJ Announces $345 Million Settlement with Community Health Network Over Stark Law Violations

North Texas Medical Center Pays $14.2 Million To Resolve Potential False Claims Act Liability For Self-Reported Violations Of Medicare Regs, Stark Law

Florida Man Sentenced to 96 Months in Prison for Role in Multimillion-Dollar Health Care Kickback Scheme

...reaches $608,296 settlement with dentist who violated federal anti-kickback law

MMM Holdings, LLC Agrees to Pay 15.2 Million Dollars to Resolve Allegations that it Violated the False Claims Act and Anti-Kickback Statute

New York-Presbyterian/Brooklyn Methodist Hospita Settles Health Care Fraud Claims for $17.3 Million

Documentation Guidelines - Cloning

Cloning: This practice involves copying and pasting previously recorded information from a prior note into a new note which may call the integrity of the note in question.

The use of system-approved templates can help promote efficiency but can also be misused if providers clone prior information without updating it based on the current presentation of the patient.

In its 2013 work plan, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) indicated that due to the growing problem of cloning, its staff would be paying close attention to EHR cloning.

The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable.

Documentation Guidelines: Split/Shared Services

Split/Shared Definition

- A split/shared visit is an evaluation and management (E/M) visit performed by both a physician and a non-physician practitioner (NPP) from the same group in a hospital or outpatient hospital setting. Either the physician or the NPP can bill for the service if they provide it independently, **but not both**.

Substantive Portion

- The practitioner who performs the substantive portion of the visit can bill for the split/shared E/M visit.

Substantive Portion Criteria

- More than half of the total time spent on the visit.
- A substantive part of the medical decision making (MDM) involved.

Documentation Requirements

- Both the physician and NPP MUST document their contributions to the visit. The documentation should clearly indicate the total time spent and the specific tasks performed by each practitioner.

Billing Requirement

- Append the "FS" modifier to the appropriate Evaluation and Management (E/M) CPT code on the claim.

Type of Service Scenarios & Documentation Requirements

Type of Visit	Who is Involved?	Place of Service/Service Type	MD Supervision/ Presence	Documentation Requirements
Teaching Physician	Physician + Resident	• Any POS • Any Service	Personal Presence & Supervision	MD personally document or personally attest.
Incident To	NPP w/same employer as MD	• Office • Est. E/M and established POC	MD in Office and available	MD personally attest to supervision
Shared Service	NPP w/same employer as MD	• Other OP, IP, ED & Critical Care • E&M Service	Personal Involvement and must identify the two individuals sharing the services.	Each personally document extent of service personally performed. Billed w/Modifier FS Both must be eligible to bill independently
Scribe	Non-clinician (scribe)	• Any POS • Usually E&M	Personally Performed by MD	MD personally acknowledge Scribe note & accept.

General Documentation Requirements – E/M Services

Both you and the resident may document in the patient's medical record.
Documentation must be dated and contain a legible signature(s) or identities and may be completed using one of these methods:

- Dictated & transcribed
- Typed
- Hand-written or
- Computer-generated

When billing for E/M service, the teaching physician must personally document all of the following:

- That you performed the service or were physically present during the critical or key portions of the service furnished by the resident
- Your participation in the management of the patient

Teaching Physician Requirements for Surgical & Other High-Risk Procedures

- The teaching physician must be ***present during all critical and key portions*** of the procedure

- ***Must be immediately available*** to furnish services during the entire procedure.

In the News!

Aug. 31, 2023, 5:00 AM

Bloomberg Law

Doctors Ghost Patients, Charge for Surgeries Left to Residents

- False claims lawsuits expose little-known practice
- Doctors at teaching hospitals say patients must be informed

Doctors at some of the largest US teaching hospitals are blowing the whistle on a lucrative practice they say endangers patients: Surgeons scheduling two or even three operations at virtually the same time, leaving during critical portions, then billing Medicare for work they didn't do.

The University of Southern California's hospital system is accused of billing for thousands of cases - costing taxpayers "hundreds of millions of dollars" - where the teaching physician left residents unattended to perform even spine and brain surgeries. When one doctor confronted a department head about an "embarrassingly high" rate of surgical injuries at one of its facilities, the administrator responded, according to the lawsuit:

"Well, that's where the residents go to practice on the poor folks."

In the News!

When Doctors Overbook

Doctors at teaching hospitals are blowing the whistle on surgeons who schedule multiple operations at the same time, then leave residents to finish without proper supervision. Below is a look at some of the largest ongoing cases and recent settlements.

Lenox Hospital

Status
Closed

The New York hospital agreed to pay the Justice Department $12.3 million in 2019 to settle charges that it billed for hundreds of surgeries its star doctor, David Samadi, did not directly perform. Samadi bounced from operating room to operating room, leaving unsuspecting patients in the care of residents, the DOJ said.

University of Pittsburgh Medical Center

Status
Settled (without admitting wrongdoing)

The Department of Justice alleged the University of Pittsburgh Medical Center's concurrent surgical practices defied the standard of care, abused patients' trust, inflated the time patients are under anesthesia, increased the risk of complications, and led to at least two amputations.

Massachusetts General Hospital

Status
Closed

Mass General paid $14.6 million in 2022 to settle a False Claims Act lawsuit brought by former anesthesiologist Lisa Wollman. In all the hospital paid more than $32 million to settle lawsuits accusing the several orthopedic surgeons of performing concurrent surgeries, leaving patients on operating tables and under anesthesia far longer than medically prudent.

Teaching Physician/Surgeon Requirements for Surgical Services

Surgical Services	Teaching Surgeon Requirements
Major Procedures, including endoscopic surgery	Major surgical procedures **require the surgeon's presence during key or critical portions of the procedure.** The teaching physician **must be immediately available for the entire procedure** and able to return to the procedure if needed. If they are not immediately available, then they **must arrange for another qualified surgeon to be available and document who is in their attestation.** The attending determines which part of the procedure is key/critical. The surgeon or resident may document the presence if the teaching surgeon is present for the entire surgery. WCM policy requires the teaching surgeon to attest to the operative note. For two concurrent surgeries, the surgeon must document his/her own presence during critical or key portions of the procedure. Key/critical components may not take place at the same time for concurrent surgeries. The surgeon must designate **(and document)** another surgeon who can provide assistance if needed if they are not available. You cannot bill for three concurrent surgeries at the same time. Participating in three concurrent surgeries would make all three non-billable.
Minor Procedures	For teaching physician rule purposes only, minor procedures are defined as services that take less than 5 minutes • The TP must be present the entire time • WCM policy the TP must attest to the operative report
Endoscopy	• The teaching physician **must be present in the room for the entire procedure from the time the scope is inserted to the time the scope is removed.** • WCM policy requires that the TP must attest to the operative report.

Teaching Physician **Attestation** Requirements for Surgical Services

Surgical Services	Teaching Physician Requirements
Surgeon Presence for Entire Case	The attending physician/surgeon must be physically present for the entire duration of the procedure, including the **pre-operative timeout**, **key/critical portions**, and the **post-operative debrief**. Example of Attestation: **"I was physically present for the entire procedure."**
Surgeon Presence for Key/Critical Portion	**Key/critical portions** of two overlapping or concurrent procedures **cannot occur simultaneously under the supervision of a single surgeon**. Examples of Attestations: **"I was physically present for the key/critical portions of the procedure and immediately available during the non-key portions of the procedure."** **"I was physically present for the key portions of the procedure, and Dr. [xx] was the covering surgeon for the non-key portions of the procedure."**
Surgeon Presence for Endoscopic Procedures	The attending physician/surgeon must be **present during the entire duration of the scope viewing**—from insertion to removal of the scope. Examples of Attestations: **"I was physically present for the key/critical portions of the procedure, including the entire viewing of the scope and immediately available during the non-key portions of the procedure."** **"I was physically present for the entire procedure, including the entire viewing of the scope."**

In the event of unusual circumstances in which the above attestation statements are not accurate, the attestation statements MUST be modified to correctly reflect the situation.

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Types of Codes – Diagnosis, CPT Service, Modifier

Diagnosis Code (ICD-10-CM): these codes are used to describe diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury

Service Code (CPT code): are medical code sets assigned to every task and service including medical, surgical and diagnostic services a physician or other qualified health professional provides to a patient

Modifiers: Two-character modifiers are appended to CPT® codes to report or indicate that a service or procedure performed has been altered by special circumstances but has not changed the CPT definition or code.

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Overview of Diagnosis Coding

Overview of ICD-10-CM: Diagnosis Code

The ICD-10 Code Structure accommodates for the expanded number of characters in diagnosis codes.

Purpose

- Standardizes diagnosis coding worldwide
- Provides greater specificity than ICD-9
- Supports billing, quality reporting, and research

Key Features

- Over **70,000 diagnosis codes**
- Alpha-numeric, up to **7 characters**
- Captures etiology, site, severity, and encounter type
- Allows precise documentation of patient conditions

Examples

- **E11.9** – Type 2 diabetes mellitus without complications
- **S72.001A** – Fracture of unspecified part of neck of right femur, initial encounter

Diagnosis Code Requirements

All diagnoses being managed, evaluated, assessed, and/or treated (MEAT) should be documented and submitted for billing.

M – Monitoring signs, symptoms, disease progression, disease regression

E – Evaluating test results, medication effectiveness, response to treatment

A – Assessing/Addressing ordered tests, discussion, review records, and counseling patient

T – Treating medications, therapies, and other modalities

Diagnosis Coding

Selection of Principal Diagnosis	The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient admission to the hospital for care.
Order of Importance	• **Definitive Diagnosis**-when a condition has been established use the most specific code. • **Signs and symptoms**-codes that describe symptoms and signs, are acceptable for reporting when a related definitive diagnosis has not been established by the end of the encounter.
History (of) "Z codes"	• **Personal history** codes explain a patient's past's medical condition that no longer exist and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring • **Family history** are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.
Uncertain Diagnosis (inpatient setting only)	If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", "compatible with", "consistent with" or similar terms indicating uncertainty code the condition as if it existed or was established.
Use of External Causes of Morbidity (V00-Y99)	These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).

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Overview of CPT Codes

Types of Codes

Code Type	Description
CPT Category I (Level I)	These codes have descriptors that correspond to a procedure or service. CPT code range from 00100-99499 and are generally ordered into sub-categories based on procedure/service type and anatomy ➢ **Category II**-These alphanumeric tracking codes are supplemental codes used for performance measurement. ➢ **Category III**-These are temporary alphanumeric codes for new and developing technology, procedures and services. They were created for data collection, assessment and in some instances, payment of new services and procedure that currently don't meet the criteria for a Category I code.
HCPCS (Level II)	**H**ealthcare **C**ommon **P**rocedure **C**oding **S**ystem (HCPCS). Level II codes are alphanumeric, with a letter occupying the first character of the code, and are designed to represent non-physician services like ambulance rides, wheelchairs, walkers, and other durable medical equipment, and other medical services that don't fit into Level I.
Level III	Codes and descriptors developed by Medicare carriers (aka Medicare Administrative Contractors; MACs) for use at the local (MAC) level. These are 5-position alpha numeric codes in the W, X, Y or Z series representing physician and non-physician services that are not represented in level I or level II codes.

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Coding for Evaluation & Management (E/M) Services

Chief Complaint

A Chief Complaint (CC) is a concise statement describing the symptom, problem, condition, diagnosis, physician-recommended return, or other factor that is the reason for a patient's medical encounter; essentially, it's the primary reason why the patient is seeking care, usually stated in their own words.

- Concise statement: The CC should briefly summarize the patient's primary concern.
- Patient-centered: Ideally, the CC should be documented using the patient's own words.
- Required documentation: Medical records must clearly reflect the patient's chief complaint.

Documentation of a Chief Complaint is required for all levels of Evaluation & Management Services.

New Patient vs. Established Patient

New Patient

A **new patient** is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

Established Patient

An **established patient** has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **same specialty and subspecialty belonging** to the same group practice within the past three years.

Note: Patients who follow their provider to a new practice or organization are still considered established patients. The provider's NPI is used to determine the patient's status.

Initial Hospital Care vs. Subsequent Hospital Care

Initial Hospital Care

An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.

Subsequent Hospital Care

The patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the admission and stay.

E/M Services is determined by MDM or Time

Determining the level of E&M is based on the following:

Medical Decision Making (MDM)

MDM is categorized into four levels: straightforward, low, moderate, and high. It is based on three components:

- Number and Complexity of Problems Addressed: The number and severity of the patient's problems.
- Amount and/or Complexity of Data to be Reviewed and Analyzed: Includes medical records, diagnostic tests, and other information that must be obtained, ordered, reviewed, and analyzed.
- Risk of Complications and/or Morbidity or Mortality: The risk associated with the patient's condition and the treatment options.

OR

Total Time

Total Time Spent: The total time spent on the day of the encounter, including both face-to-face and non-face-to-face time. This includes activities such as reviewing records, ordering tests, and documenting the visit.

Additional Requirements

History and/or Physical Examination

E&M codes with service levels include a medically appropriate history and/or physical examination when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified healthcare professional reporting the service. History and physical examination **are not** elements in the selection of the level of the E&M services.

Let's Focus on **Time** as the basis for Code Selection

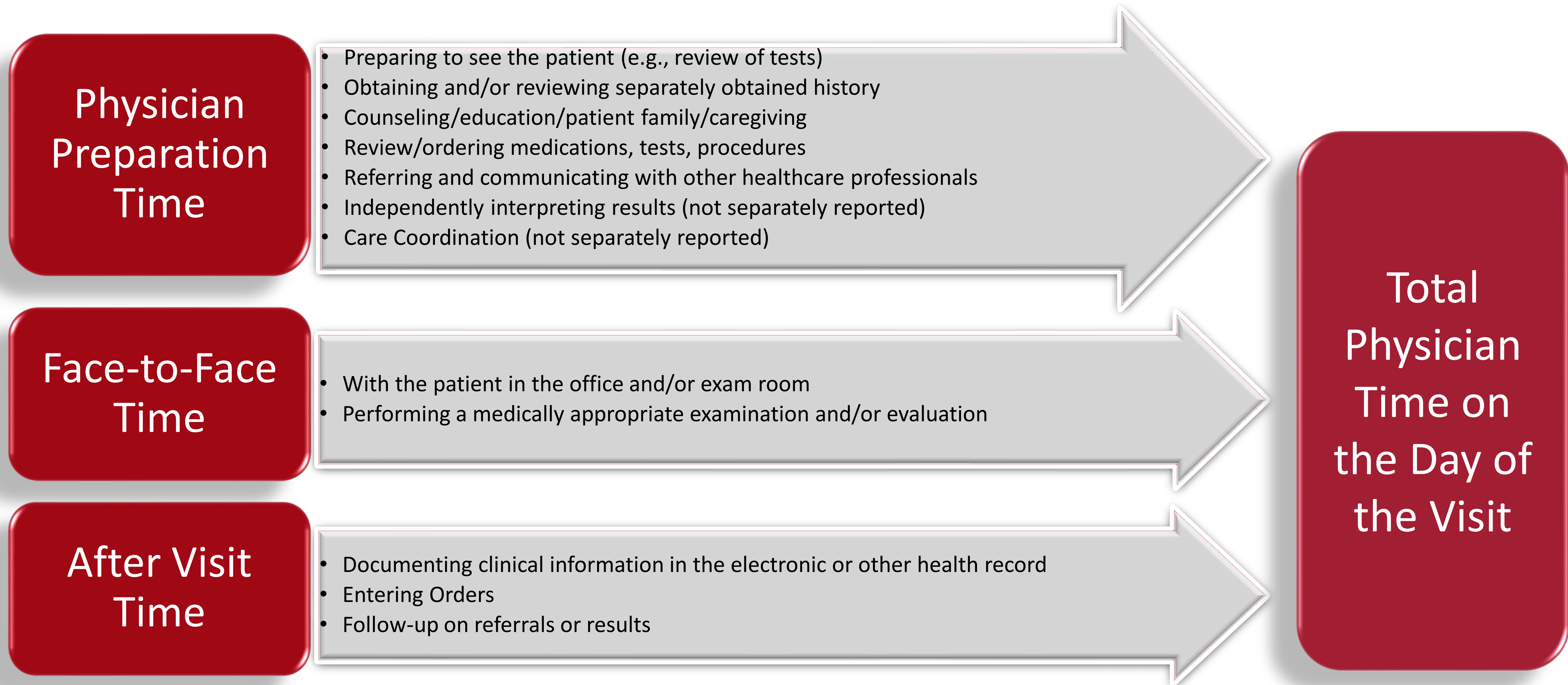
Time alone may be used to select the appropriate E/M code **except** for Emergency Medicine Services (99281-99285).

Time may be used when the total time spent on a patient encounter on the service date is documented. Each E/M code has a single "minimum time threshold" that must be met or exceeded rather than a time range.

These services do require a face-to-face encounter, but face-to-face and non-face-to-face time personally spent by the provider on the date of the encounter counts toward the total reported time.

The time defined in the code descriptor is used to select the appropriate service level. Time spent on the date of the encounter and describing what was done should be documented in the medical record when used as the basis for code selection.

Same Day Activities included in E/M by Time



- Time can only be reported by a provider or other qualified healthcare professional.
- Time cannot be reported for services performed by ancillary staff, RNs, or residents.

Outpatient E/M Services 99202-99215

New Patient
Time-Based Codes

CPT Code	Meet or Exceed
99202	15 Minutes
99203	30 Minutes
99204	45 Minutes
99205	60 Minutes

Established Patient
Time-Based Codes

CPT Code	Meet or Exceed
99212	10 Minutes
99213	20 Minutes
99214	30 Minutes
99215	40 Minutes

The provider must describe what was done, and include total time on the date of service in statement for example:

"I spent XX minutes reviewing the patient's diagnostic test, examining the patient, speaking with the radiologist regarding the results, and documenting in the patient's medical record."

Outpatient Prolonged Services: HCPCS G2212 & CPT 99417

HCPCS code G2212

Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; **each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact for **Medicare patients.**

CPT code 99417

Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond **each additional 15 minutes** of the required time of the primary service when the primary service level has been selected using total time, of total time

Documentation Requirements

Total Time: Document the total time spent on the encounter, including both face-to-face and non-face-to-face time. This includes activities such as reviewing records, ordering tests, and documenting the visit.

Prolonged Services: Ensure that the additional time spent is clearly documented and meets the minimum threshold of 15 minutes beyond the primary E/M service.

Billing Guidelines

Report G2212 or 99417 in addition to the primary E/M code (99205 or 99215) when the total time exceeds the threshold.

Each unit of G2212 or 99417 represents an additional 15 minutes of prolonged service.

Outpatient Codes for Prolonged Services: HCPCS G2212 & CPT 99417

CPT	CPT Total Time Required for Reporting	Prolonged Services CPT	Prolonged Services HCPCS (Medicare Only)
99205	60-74 minutes	N/A	
99205 x 1	89-103 minutes	99417 x 1	G2212 x 1
99205 x 1	104-118 minutes	99417 x 2	G2212 x 2
99215	40-54 minutes	N/A	
99215 x 1	69-83 minutes	99417 x 1	G2212 x 1
99215 x 1	84-98 minutes	99417 x 2	G2212 x 2
99215 x 1	99 or more minutes	99417 x 3	G2212 x 3

Total time is all of the reportable time, including prolonged time you spent with the patient on the date of service of the visit. ***You may count these activities when:***

- ❑ *You use the time to select your visit level; and*
- ❑ *Your services are medically reasonable and necessary*

Inpatient Prolonged Services: HCPCS G0316 & CPT 99418

HCPCS Code G0316 (Medicare Only)

Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service; **each additional 15 minutes** by the physician or qualified healthcare professional, with or without direct patient contact. Report in addition to CPT codes 99223 and 99233 for hospital inpatient or observation care E/M services for **Medicare Patients.**

Documentation Requirements:

Document total time spent on the encounter, including face-to-face and non-face-to-face time. Ensure additional time meets the minimum threshold of 15 minutes beyond the primary E/M service. Do not report G0316 with other primary services or for any time unit less than 15 minutes.

CPT Code 99418

Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service, each additional 15 minutes.

Report in addition to the highest-level initial and subsequent nursing facility care E/M codes.

Documentation Requirements:

Document total time spent on the encounter, including both face-to-face and non-face-to-face time. Ensure additional time meets the minimum threshold of 15 minutes beyond the primary E/M service.

Billing Guidelines:

Report 99418 in addition to the primary E/M code when the total time exceeds the threshold. Each unit of 99418 represents an additional 15 minutes of prolonged service.

Inpatient Codes for Prolonged Services: HSPCS G0316 & CPT 99418

CPT	CPT Total Time Required for Reporting	Prolonged Services CPT (Non-Medicare Payers)	Prolonged Services HCPCS (Medicare Only)
99223	75-89 minutes	N/A	
99223	90-104 minutes	99418 x 1	G0316 x 1
99223	105-119 minutes	99418 x 2	G0316 x 2
99233	50 minutes	N/A	
99233	65-79 minutes	99418 x 1	G0316 x 1
99233	80-94 minutes	99418 x 2	G0316 x 2

Total time is all of the reportable time, including prolonged time you spent with the patient on the date of service of the visit. ***You may count these activities when:***

- ❑ *You use the time to select your visit level; and*
- ❑ *Your services are medically reasonable and necessary*

Let's Focus on **Medical Decision Making (MDM)** as the basis for Code Selection

Quantity and Complexity

- Number and **Complexity of Problems Addressed at the Encounter**

Effort and Documented Analysis

- Amount and/or Complexity of Data to be Reviewed **and Analyzed**

Risk and Specific to Patient Management

- Risk of Complications and/or Morbidity or Mortality **of Patient Management**

Straightforward MDM

Level of MDM (Based on 2 out of 3 Elements of MDM	CPT Codes	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data To Be Reviewed and Analyzed * Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity of Mortality of Patient Management
Straightforward	99202 99212 99221 99231 99234 99282 99341 99347	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

Low MDM

Level of MDM (Based on 2 out of 3 Elements of MDM	CPT	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data To Be Reviewed and Analyzed * Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity of Mortality of Patient Management
Low	99203 99213 99221 99231 99234 99283 99342 99348	Low • 2 or more self-limited or minor problems; • 1 stable, chronic illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (1 out of 2 categories) Category 1: Test and documents ▪ Any combination of 2 from the following • Review of prior external note(s) from each unique source • Review of result(s) of each unique test • Ordering of each unique test Category 2: Assessment requiring an independent historian(s). (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	Low risk of morbidity from additional diagnostic testing or treatment

Moderate MDM

Level of MDM (Based on 2 out of 3 Elements of MDM	CPT	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data To Be Reviewed and Analyzed * Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity of Mortality of Patient Management
Moderate	99204 99214 99222 99232 99235 99284 99344 99349	Moderate • 1 or more chronic illnesses w/exacerbation, progression, or side effects of treatment; • 2 or more stable, chronic illnesses; • 1 undiagnosed new problem w/certain prognosis; • 1 acute illness w/systemic symptoms; • 1 acute, complicated injury	Moderate (1 out of 3 categories) Category 1: Test and documents ▪ Any combination of 3 from the following • Review of prior external note(s) from each unique source • Review of result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) Category 2: Independent interpretation of tests Category 3: Discussion of management or test interpretation	Moderate risk of morbidity from additional diagnostic testing or treatment Example only: • Prescription drug management • Decision regarding minor surgery w/identified patient or procedure risk factors • Decision regarding elective major surgery w/o identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

High MDM

Level of MDM (Based on 2 out of 3 Elements of MDM	CPT	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data To Be Reviewed and Analyzed * Each unique test, order or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity of Mortality of Patient Management
High	99205 99215 99223 99233 99236 99285 99345 99350	High • 1 or more chronic illnesses w/ severe exacerbation, progression, or side effects of treatment; • 1 acute or chronic illness or injury that poses a threat to life or bodily function	High (2 out of 3 categories) **Category 1:** Test and documents ▪ Any combination of 3 from the following • Review of prior external note(s) from each unique source • Review of result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s) **Category 2:** Independent interpretation of tests **Category 3:** Discussion of management or test interpretation	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery w/identified risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital level care • Decision not to resuscitate or to deescalate care because of poor prognosis • Parenteral controlled substances

Initial Hospital Inpatient

CPT	Code Description	Total Time in minutes on the date of encounter must be met or exceeded (if billing based on time)
99221	Per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straightforward** or **low**-level medical decision making	**40 minutes**
99222	Per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate** level medical decision making	**55 minutes**
99223	Per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **high-**level medical decision making	**75 minutes**

For services 90 minutes or longer, use prolonged services code 99418
Medicare: For services 105 minutes or longer, use prolonged services code G0316

99477	For admission services for the **neonate (28 days of age or younger)** requiring intensive observation, frequent interventions, and other intensive care services

Subsequent Hospital Inpatient

CPT	Code Description	Total Time in minutes on the date of encounter must be met or exceeded (if billing based on time)
99231	Per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straightforward** or **low-level** medical decision making	**25 minutes**
99232	Per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate level** medical decision making	**35 minutes**
99233	Per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **high-level** medical decision making	**50 minutes**

For services 65 minutes or longer, use prolonged services code 99418.
Medicare: For services 80 minutes or longer, use prolonged services code G0316.

Department of Emergency Medicine (ED) Services

Time is NOT a factor in the Emergency Department Services

- Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters by the same physician or other qualified health professional with several patients over an extended period of time.

CPT	Code Descriptors
99281	Emergency department visit for the evaluation & management of a patient that **may not require** the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation & management of a patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making
99283	Emergency department visit for the evaluation & management of a patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making
99284	Emergency department visit for the evaluation & management of a patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making
99285	Emergency department visit for the evaluation & management of a patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making

When to Bill for Critical Care Services

When providing services for critically ill or injured patients where the patient has a high probability of imminent or life-threatening deterioration due to acute impairment of one or more vital organ systems, requiring complex decision-making to manage the situation; essentially, providing intensive care to a patient with a potentially unstable condition requiring close monitoring and intervention, critical care coding should be used.

Criteria:

- Patient must be critically ill or injured.
- Critical care involves high complexity decision making to assess, manipulate, and support vital system functions.
- Critical care services must be medically necessary and reasonable.

Examples of Critical Care Situations:

- Acute respiratory failure
- Shock
- Severe trauma
- Life-threatening infections

Critical Care CPT Codes 99291 and 99292

CPT Code 99291

- Evaluation and management of the critically ill or critically injured patient during the first 30-74 minutes of critical care on a given calendar date.
- Report the first 30-74 minutes of critical care provided to a patient.

CPT Code 99292

- Each additional 30 minutes of critical care beyond the first 74 minutes.
- Report additional time spent on critical care for a minimum of 104 minutes.

Documentation Requirements for Critical Care Services

General Requirements:

- Time spent providing critical care must be documented.
- The nature of the critical illness or injury and the necessity for critical care must be clearly stated.
- Details of the high complexity decision making involved.

Specific Elements to Include:

- Patient's Condition: Description of the critical illness or injury.
- Interventions: Specific treatments and interventions provided.
- Time: Total time spent on critical care, including start and end times.
- Decision Making: Documentation of the high complexity decision making process.
- Coordination of Care: Any coordination with other healthcare providers.

Medicare NGS Medicare Guidelines

- Billing Sequence: If an emergency department (ED) service is provided first, it must be billed before critical care services (CPT codes 99282–99285 followed by 99291–99292) with modifier 25 added.

Time Chart for Billing Critical Care Services

Total Duration of Critical Care Time	CPT Codes
Less than 30 minutes	Report using the appropriate E/M code, not 99291
30-74 minutes	99291
104 minutes	99291 and 99292
134 minutes	99291 and 99292 x 2
164 minutes	99291 and 99292 x 3
194 minutes	99291 and 99292 x 4

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Overview of Modifiers

Commonly Used Modifiers

A modifier is a two-character code that provides additional information about a procedure or service that was performed and may impact billing.

Modifier	Description
24	Modifier **24** is appended to an evaluation and management service (never to a procedure) to indicate that an unrelated E&M service was provided by the same physician during a postoperative period. Other, "same-specialty physicians" are included in the definition of "same physician.“
25	Modifier **25** (significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service) is the most important modifier for pediatricians in Current Procedural Terminology (CPT®). It creates the opportunity to capture physician work done when separate E/M services are provided at the time of another E/M visit or procedural service.
50	Modifier **50** is used to report bilateral procedures that are performed during the same operative session by the same physician in either separate operative areas (e.g., hands, feet, legs, arms, ears), or one (same) operative area (e.g., nose, eyes, breasts).
59	Modifier **59** is used to identify procedures/services that are not normally reported together but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

Modifier JW: Drug Amount Discarded/Not Administered

Modifier JW is utilized to report the quantity of a drug that is discarded and qualifies for payment under Medicare's discarded drug policy. This modifier ensures accurate billing for drugs that come in single-dose containers when a portion of the drug is not administered to the patient. It is applicable only to drugs in single-dose containers where a part of the drug remains unused.

Documentation

- Record the total amount of the drug administered and the amount discarded in the patient's medical record.
- Ensure the discarded amount is separately and clearly documented.

Billing Requirements

- Submit two lines for the drug:
  - **First Line**: Report the amount administered to the patient.
  - **Second Line**: Use Modifier JW to report the amount discarded.

Outpatient E/M Services Cannot Be Billed During Inpatient Admission

Single Payment System:

- Medicare covers all necessary treatments and procedures during an inpatient stay under a single payment.
- Outpatient E/M services provided during this period are included in the inpatient payment.

Avoiding Duplicate Payments:

- Separate billing for outpatient E/M services during an inpatient stay could lead to duplicate payments.
- Medicare ensures all services are billed together to prevent this.

Integrated Care:

- Inpatient care is comprehensive, covering all aspects of treatment.
- Outpatient E/M services during an inpatient stay are part of the overall care plan and billed as inpatient services.

Regulatory Compliance:

- Medicare regulations prohibit separate billing for outpatient services when a patient is admitted as an inpatient.
- Ensures compliance with Medicare's billing policies and prevents potential fraud or abuse.

Impact of Patient’s Facility Setting on Professional Billing

When a patient is admitted to one of the following facilities, the physician bills only for the professional component under Medicare Part B. All technical fees are included in the facility's billing. **Modifier 26 may be used for diagnostic testing.**

- Skilled Nursing Facility
- Comprehensive Outpatient Rehabilitation Facility (CORF) Services
- Comprehensive Inpatient Rehabilitation Facility (CIRF) Services
- Outpatient Rehabilitation Therapy Services
- Inpatient Psychiatric Facility
- Psychiatric Residential Treatment Center

OOC's Audit & Monitoring Plan

Common High-Risk Areas

- Evaluation and Management Services
- Physicians at Teaching Hospitals
- Probe Reviews
- Risk Based Audits
- Supervision of NPPs
- New Providers
- Critical Care Services
- Research Billing
- The use of Modifier 25
- The use of Modifier 62
- The use of Modifier 82

Examples of Audit Workplan Focus Areas

RISK AREA	ACTIVITY
Time Based Billing	• Quarterly Review Of Hours Billed To Identify Outliers • Critical Care
Cloned Notes	• Sampling Consecutive E/M Notes For Same Patient • Hover for Details • Quality, Billing Integrity And Technology Impact
Risk-based	• Review OIG Work Plan • Department’s Request
Research Billing	• Identify and correct process errors and gaps that may lead to non-compliant billing • Clinical Trials with active enrollment are reviewed
New Provider Review	• All providers new to billing are reviewed
Probe Reviews	• Conduct retrospective/prospective review to identify potential overpayment

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Compliance Sets the Rules… **Privacy** Protects the Patient

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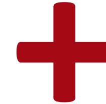
Compliance with Privacy Rules

Why is HIPAA Training Important?

- Provides a framework for establishment of nationwide protection of patient confidentiality, security of electronic systems, and standards and requirements for electronic transmission of health information
- As a covered entity, we are required to comply with HIPAA regulations
- Our patients are placing their trust in us to preserve the privacy of their personal information
- Shows our commitment to managing protected health information with the same care and respect as we expect of our own private information
- If we don't follow the rules…
  - **You could be put at risk,**
    - financial including personal penalties and sanctions
    - reputational harm

PHI = Individual Identifier + Health Information

1. Patient names
2. Geographical elements
3. Dates
4. Telephone numbers
5. Fax numbers
6. Email addresses
7. Social Security numbers
8. Medical record numbers
9. Health insurance beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers
13. Device identifiers
14. URLs
15. IP Addresses
16. Biometric identifiers
17. Facial images
18. Any other unique identifiers



- Clinical data/Diagnosis data
- Patient's health care provider
- Patient's health care provider for sensitive conditions
- Patient's location in facility
- Personal Health Condition or History
- Pregnancy
- Prescription drug usage or usage history
- Addiction
- Behavioral Health Information or History
- Family Health Condition or History
- Health Insurance Application, Claims History, or Appeals Records
- Interest in clinical trial research

What are Uses and Disclosures?

- **Uses**

  When we review or use PHI internally (i.e., audits, training, customer service, coordination of care)

- **Disclosures**

  When we release or provide PHI to someone (i.e., patient/patient representative, attorney, another provider)

Notice of Privacy Practices (NPP)

Notice of Privacy Practices

YOUR INFORMATION • YOUR RIGHTS • OUR RESPONSIBILITIES

Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University participate in an Organized Health Care Arrangement (OHCA). This allows us to share health information to carry out treatment, payment and joint health care operations relating to the OHCA, including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities. Organizations that will follow this notice include Weill Cornell Medicine, NewYork-Presbyterian sites, Columbia University and their entities.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

This page is intended as a summary of the Notice. Please review the remainder of the Notice for more details.

Your Rights

You have the right to:

- Request a copy of your paper or electronic medical record
- Request a correction to your paper or electronic medical record
- Request confidential communications
- Ask us to limit the information we share
- Get a list of certain disclosures we have made of your information
- Get a copy of this privacy notice
- Choose someone to act for you, in accordance with certain legal requirements
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Include you in a hospital directory
- Raise funds & Marketing Purposes

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Assist in a disaster relief effort

1

- **Provided to all WCM patients**
- **Patients acknowledge receipt**
- **Available on website**
- **Tells patient:**
  - ➢ WCM's permitted Use and Disclosure of PHI
    - ✓ Including research
  - ➢ Patient Rights Regarding Their PHI

Permitted Uses & Disclosures

Treatment
- Doctor/Nurse/Medical Assistant
- Dentist/Chiropractor
- Patient Referrals/Consults
- Laboratories/Blood work

Payment
- Health Care Claims
- Workers Compensation
- Consumer Reporting Agencies
- Utilization Review

Health Care Operations
- Quality Assurance Purposes
- Internal Audits/Assessments
- Medical Student Training
- Financial Activities

Safeguarding Patient Information

HIPAA Security Rule

The HIPAA Security Rule requires covered entities and business associates to do the following:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information PHI that is created, received, maintained or transmitted

- Protect against any reasonably anticipated threats or hazards to the security or integrity of PHI

- Protect against any reasonably anticipated uses or disclosures of PHI that are not permitted or required under the Privacy Rule

- Ensure compliance with security by its workforce

Types of Required Safeguards

Technical Safeguards

- Unique user IDs and secure logins
- Role-based access controls
- Automatic logoff and encryption
- Monitoring and auditing of system activity

Administrative Safeguards

- Security management processes (e.g., risk assessments)
- Workforce training and awareness
- Sanction policies for violations
- Contingency planning and access controls

Physical Safeguards

- Secure facility access controls
- Workstation use and security policies
- Device and media control (e.g., secure disposal)

WCM Security Highlights

- Use of Duo two-factor authentication
- Encrypted laptops and mobile devices
- Security awareness training for all staff and students
- Incident response protocols and regular security assessments
- Alignment with ITS and Compliance policy frameworks

Minimum Necessary Standards

<u>Minimum Necessary</u>: Members of the workforce should *only* access and/or use/disclose the *minimum* amount, and *correct type*, of PHI *necessary* to fulfill their assigned and authorized WCMC responsibilities; and/or fulfill a specific job-related task.

1

- It is never acceptable for an employee to look at PHI just out of curiosity.

2

- It is prohibited for a workforce member to view the record of **him/herself** outside the scope of their authorized job duties.

3

- It is prohibited for a workforce member to view the record of a family member, friend or other acquaintances outside the scope of their authorized job duties.

Research & HIPAA

HIPAA does not replace or modify the HHS Common Rule or FDA regulations—it works in addition to these requirements to protect individuals' health information in research.

Key Points for Research at WCM

- HIPAA applies to human subject research, regardless of funding source
- Research use of PHI requires:
  - Valid patient authorization, or
  - An IRB-approved waiver of authorization
- HIPAA sets standards for de-identifying health information used in research
- HIPAA protections also extend to deceased individuals' health information (for 50 years after death)

When Is Authorization Required?

- Using PHI for recruitment, study data collection, or outcomes analysis
- Disclosing PHI to external sponsors or collaborators

***Always consult with **WCM's IRB** and **Privacy Office** before using PHI in research.

Phishing

Phishing is a type of email scam designed to trick you into taking actions you normally wouldn't such as:

- Provide a valuable password to a hacker (email, financial, etc.)
- Send money or gift cards to a hacker
- Install "legitimate" software that provides a hacker access to your computer

Things to ask yourself:

Is there a sense of urgency? I need this done today!	Do you know the sender? christy@hotmail.com	Spelling or grammar mistakes? Helo goood day;	Links to strange places? www.bank.com actually goes to docs.google.com

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Safeguarding WCM Data

- Be aware of suspicious emails and websites
- Use Multi-Factor Authentication (MFA)

  Create a strong password, protect it and don't share it
- Lock office doors and cabinets
- Use authorized encrypted devices only for

  WCM work
- Validate 3 or more data points before matching or combining data
- Avoid creating extra WCM data sets Do not retain information for longer than necessary
- If traveling with WCM data, ensure it's safeguarded
- Obtaining proper consent or approval for using patient/subject information related to research protocols
- Use encryption when emailing WCM data externally
- Lock up or log off your computer when walking away
- Only exchange WCM Data with authorized vendors or 3rd parties
- Be discrete when discussing patient/subject information in open areas or when leaving messages
- Use shredding bins to dispose of patient/subject information
- Avoid saving files with identifiable information in the title.
- Only using approved AI tools with

  WCM Data
- Control printed materials on the printer/fax; keep in a secure area

WCM Email and Electronic Device Best Practices

Emails

- Use your institutional email address for correspondence
- Do not use rules to forward emails outside of WCM data
- Confirm all recipients are correct and valid sending emails
- For large data sets or attachments containing WCM data, use the File Transfer Service (https://transfer.weill.cornell.edu) to send to authorized external recipients
- If you receive a suspicious email:
  - Report the message as spam to ITS Security
  - Delete the message from your inbox
  - DO NOT click on any links in the email
  - DO NOT open any suspicious or unexpected attachment

Computers and Mobile Devices

- If using a mobile device for WCM business, get the device tagged by ITS Helpdesk at WCM
  - Tagging your device will protect it from unauthorized access if lost or stolen by utilizing encryption
  - All devices connected to the WCM networks and systems must be encrypted
- Use authorized portable USB storage drives that are encrypted if storing WCM data
- All devices used for work should have up to date antivirus software installed
- Never allow anyone to work under your CWID and password
- Always lock your screen when leaving your workstation

What is a Breach?

An impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the PHI.

An impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity or business associate, demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment.

Breach Notification

If the incident is determined to be a breach. The following notifications are required:

- The Department of Health and Human Services (HHS)
- New York State
- Individuals whose information was breached or disclosed
- Media (if breach affects 500 or more individuals)

Common WCM Privacy Incidents

Electronic “ePHI”
WCM employee accessing patient information in the EMR without a legitimate work-related reason, including for unapproved research activities
A lost or stolen laptop or portable media device containing WCM data (encrypted and non-encrypted)
Exchanging WCM data with a vendor or 3rd party without the proper agreements or approval
Patient/subject information being uploaded, texted or emailed to the wrong external recipient
Using unauthorized platforms to communicate or exchange WCM data
2 or more WCM employees sharing a password to systems containing patient/subject data
Patient/subject data posted to, or leaked to, social media
Suspicious emails requesting your password or personal information to update your account

Paper/Fax/Specimen
Medical information sent to the wrong address
Paper records being improperly disposed of – not scanned in the EMR or secure platform
Bloodwork taken from an unlocked laboratory specimen box
The wrong patient/subject label attached to a specimen

Oral
Clinicians or research staff discussing a patient’s care in an elevator
Patient/subject information verbally shared with another person who has no need to know (gossip)
Any WCM staff discussing a patient/subject case over dinner with friends

Summary

- HIPAA Compliance is Everyone's Responsibility!
- HIPAA Training is not "ONCE & DONE"
  - **Increase Awareness Through Discussion, Meetings, Frequent Reminders**
- Self Audit
  - **Look for HIPAA Risks & Implement Corrective Action**
- All HIPAA Incidents Must Be Reported

How to report a Privacy or Security Concern

Privacy

- **Phone:** 646-962-6930
- **Email:** privacy@med.cornell.edu
- **Website:** https://compliance.weill.cornell.edu/privacy/submit-privacy-incident

Security

- **Phone**: 646-962-3010
- **Email:**its-security@med.cornell.edu
- **Website:** https://its.weill.cornell.edu/

Hotline

- **Phone:** 866-293-3077
- **Website:** https://news.weill.cornell.edu/news/2005/01/cornell-hotline-gives-university-community-another-tool-to-report-financial-reporting-concerns

WCM's policy prohibits retaliation for reporting concerns related to compliance and privacy.

Questions

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