Message From Neil Schorr
Interim Vice President of Ethics and Compliance

Our second Newsletter is being issued just after the end of the fiscal year. Although the Office of Ethics & Compliance (OEC) is a relatively new organization and we have experienced some of the normal “growing pains”, Fiscal Year 2008 has been a very productive one for us. My comments in this issue, however, will focus on the Ethics Helpline and our efforts to resolve matters referred to us.

OEC sponsors an enhanced toll-free employee Ethics Helpline (800-215-9664), operated by an outside vendor, Global Compliance, one of the largest employee hotline companies. Additionally, employees can submit their ethics and compliance concerns through a web-page (www.umdNJ-ethics-helpline.com) also managed by Global. Reports are always kept confidential and can be provided anonymously. OEC’s Case Manager monitors referrals from Global, as well as those made directly to our unit Compliance Officers or other OEC personnel.

You may be asking, “How many submissions have been received by OEC?”, and “What have they done with them?”, and, “What were the results?”. These are fair questions, and I would like to share with you how we are now responding to submissions.

There are two charts appearing later in this Newsletter. Chart #1 details the number of cases resulting from Helpline and direct intake submissions, and Chart #2 shows how they were resolved. The process is as follows--all submissions are entered into the Global system, whether if entered directly by Global (for those made to the Helpline or web-site), or by our Case Manager (for direct intake). The information is evaluated, and depending on the nature of the submission, referred to the Investigations Group-Office of Internal Audit, the Labor & Employment Group-Office of Legal Management, or Human Resources.

Frequently, OEC Compliance Officers and Auditors, and Compliance Investigators, work together to objectively gather the facts and report their findings. Their reports are forwarded to management for appropriate attention. Follow-up action is monitored by OEC. At times, investigations disclose systemic issues, which may be appropriately referred to management, one of our Compliance Officers, or Internal Auditors for their attention.

Much of the information we receive can be categorized as “labor & employment” issues, versus legal or regulatory compliance issues. In most instances, these are referred to the Labor & Employment Group. When appropriate, the Labor & Employment Group conducts interventions at particular departments or locations, to address reported issues. On the Chart #2, these interventions appear under the resolution category of “resolved”.

President Owen has sponsored “The Zero Tolerance for Inappropriate Behavior” initiative, in which he encourages all team members to report their ethical or compliance concerns, without fear of retaliation. OEC strongly supports this policy, and in fact, it is a primary reason for OEC’s very existence. No action will be taken against an employee because he or she made a report in good faith. We must, however, maintain a balance. As you can see from Chart #2, after investigation, a large proportion of the submissions were found to be “unsubstantiated”. This is alright, so long as submissions are made honestly and without malice. Unfortunately, we have found a few situations where team members have made accusations against other team members, which were not only unsubstantiated, but were either made with reckless disregard for the facts, or worse yet, made knowing that the information provided was false. An employee need not be absolutely certain that a misdeed occurred before reporting a concern--reasonable belief is sufficient. Reporting your concerns enables us to investigate potential problems quickly, and take prompt action if the allegations are substantiated. However, for the integrity of the program, and for plain old good sense and fairness to fellow team members, reports made with reckless disregard for the facts, or made knowing that the information provided was false, will not be tolerated.

That said, I look forward to your continued support and wish you all a successful new fiscal year.

Enjoy the newsletter!

Neil Schorr
Interim Vice President
Chief Ethics & Compliance Officer
Office of Ethics & Compliance
Compliance Counts!

Charts

**Total Cases Opened by Month**
*July 1, 2007 - June 30, 2008*

Note 1: The Office of Ethics and Compliance (OEC) has received 662 cases via the Ethics Helpline and other sources from July 1, 2007 thru June 30, 2008.
Note 2: The other category located in the legend box represents mail, email and direct intake of complaints to the Office of Ethics and Compliance.

**Investigative Closed Case Results**
*July 1, 2007 - June 30, 2008*

*Chart #1* details the number of cases resulting from Helpline and direct intake submissions.

*Chart #2* details the resolution of cases resulting from Helpline and direct intake submissions.
**Ethics News**

**Records Management**

The Office of Ethics and Compliance has successfully started the implementation of a revised Records Management Policy. On April 15, 2008, UMDNJ’s Board of Trustees passed a revised Records Management Policy. However, disposal of non-records and destruction of records cannot begin until we:

- Follow the State Records Retention Guidelines
- Train our staff regarding the new policy
- Appoint Record Liaisons at each school/unit
- Institute a random audit process of shred bins to ensure only non-records are being destroyed

Each school/unit has designated a Records Liaison to coordinate records management activities. The Records Liaisons in conjunction with Joanne Cheung (OEC), Sharon Bushelli (Data Control) and Susan Glick (University’s Custodian of Records) will be training the UMDNJ community on the Records Management Policy.

Training sessions are being held on all campuses at various days/times to accommodate all schedules. Included in the training will be an explanation of records and non-records, record management tips, and the required audit procedure to ensure records are being disposed properly. Once you have received your training, the first step is to begin an inventory of your records and storage options.

For additional information please visit: [http://www.umdnj.edu/complweb/record](http://www.umdnj.edu/complweb/record)

**Ethics Responsibilities**

The New Jersey State Ethics Commission issued a mandate that each University employee review the Scholarly Capacity Impact Statement, which should be read in conjunction with the Uniform Ethics Code and the Plain Language Guide (Guide). Additionally, each University employee is required by the Commission to complete and file an acknowledgment of receipt and certification for these documents.

Each chair and department head is responsible for collecting the signed receipts and forwarding them no later than September 1, 2008 to the Office of Ethics and Compliance.

If you have any questions related to conflicts of interest or employee obligations under the Code, and Guide, please email your questions to: ethics@umdnj.edu.

**New Staff**

New Staff Member Aboard! Lisa Pleasant, Ethics Specialist has recently joined our Ethics Group. Lisa's responsibility includes State Ethics Law, Rules, Regulations and Ethics forms. Lisa will also be reviewing and coordinating the results from the review of OIG/GSA lists of excluded individuals and entities with the Schools and Units.

**NJMS and UPA Kick Off Physician Coding**

On June 9th, 10th, and 11th, the first of 4 quarterly physician training modules was conducted. Over 12 sessions in “Basic Coding for the Academic Setting” given by Dr. Carol Mahon, President of Medical Business Institute in Dallas, Texas, and her colleague Tamara Lahner, was well attended by both faculty and residents.

The remaining 3 education modules include training on “Physicians at Teaching Hospitals” rules, “Basic ICD-9 Coding” and “Advanced Coding for the Academic Setting,” and will be held in September, December and March.

In requiring the faculty and residents to attend, Dr. Robert Johnson, Interim Dean of NJMS said, “As you know, the federal government is placing increased emphasis on correct coding and documentation for medical billing. Given our experiences over the last two years, it is exceedingly important that we assure that all Clinicians understand the most current coding requirements. Therefore, we have partnered with UPA and the UMDNJ Office of Ethics and Compliance to schedule this training and accomplish our goal.”
In a recent phone conversation with a physician, we discussed the documentation guidelines and the requirement for physicians to comply with either the 1995 or 1997 set of Evaluation and Management guidelines. At the end of the conversation he asked me, “Could I have been expected to know about these guidelines?”

The answer is “Yes.” The government expects physicians and their staff to know the government regulations related to billing and submitting claims to Medicare and Medicaid -- and the government sets forth their specific concerns and areas of interest each year through the Office of Inspector General (OIG). Congress created the OIG to protect the integrity of services provided by the Department of Health and Human Services (HHS) and the beneficiaries it serves. The OIG has a responsibility to report its findings to the Secretary of HHS and to Congress, and it carries out its duties nationwide through audits, investigations, and inspections.

As part of its work, the OIG publishes an annual Work Plan that describes the areas of interest of the OIG’s work for the coming year for hospitals, physician practices, home health agencies, and other providers of healthcare. It is divided into about 20 sections; the one that relates specifically to physician practices is "Medicare Physicians and Other Health Professionals." Each year, starting in early October, clinical departments can read this section and adjust their compliance plans accordingly. The OIG Work Plan for 2008 can be found at http://www.oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf.

Figure out if you are in compliance with the OIG’s Guidance to Physicians

Many UMDNJ clinical practices have guidelines that describe their philosophy, commitment to patient care and training and the roles and responsibilities within their practice or department. And it’s true that most departments have limited resources to expend in compliance activities. But if you haven’t done so lately, it’s a good idea to get into the habit of reviewing the OIG annual Work Plan.

In addition, you should review the OIG Guidance to Physicians. In 2000, the OIG released a document that outlines the OIG’s compliance concerns for physician practices. Many clinical practices make an effort to review their compliance efforts against the annual OIG Work Plan and this Physician Guidance document. This guidance is still as relevant to physicians as it was in Y2000. You can find the Physician Guidance document at http://www.oig.hhs.gov/authorities/docs/physician.pdf.

Resources: Physician Training

Make sure your department, key staff members and physicians are up to speed on all areas of documentation, billing and coding concerns contained in the OIG Work Plan and the OIG Guidance to Physicians. In an effort to assist you in compliance, during FY2009, healthcare professionals at Robert Wood Johnson Medical School, New Jersey Medical School, New Jersey Dental School and the School of Osteopathic Medicine are being offered training sessions in the documentation, coding and billing “fundamentals” including:

- Evaluation and Management
- “Incident” to “Billing
- Acute Care Documentation
- Physician at Teaching Hospital Rules
- Consultations

Please contact the Compliance Officer for your Operating Unit if you want to arrange specialized training for your department or to obtain a list of training courses that are being offered this fiscal year.

Resources: Physician “Required” Reading

If your department is interested in reading more about the rules that always concern governmental payors, please follow these links:

- Evaluation and Management
- “Incident to” Billing
- Acute Care Documentation
- Physician at Teaching Hospital Rules
- Consultations

Note: What’s a Consultation?

Please contact the Compliance Officer for your Operating Unit or the UMDNJ Legal Management department. For example, if your review shows that a provider did not understand the difference between a new patient and an established patient, and you have reason to believe that the problem was long-standing and repetitive, you may need a different response than a voluntary refund. We are all here to help.
**Calling All Physicians**

If you think that CMS regulations only pertain to Medicare and Medicaid patients, think again. When the Centers for Medicare and Medicaid Services (CMS) mandate documentation requirements that affect quality initiatives, billing, and payment rules other payors take notice, and usually do the same. CMS is seen by all payors as a best-practice model to be followed especially since the Deficit Reduction Act of 2005 which affects domestic entitlement programs including both Medicare and Medicaid. The act addresses hospital quality improvement reporting and will be used for the reduction of payment for errors that are identifiable, preventable and affect serious consequences for patients.

Through data collection from physician documentation, or lack thereof, CMS, and other payors will be able to indicate problems of safety and quality of health care providers and facilities. The Deficit Reduction Act of 2005 requires hospitals to begin reporting whether principal and secondary diagnoses are present on admission (POA) or developed during an inpatient admission. Beginning October 2008 CMS is required to select 2 or more hospital-acquired conditions that are high cost and/or high volume and to exclude those conditions from the Diagnosis Related Group (DRG) calculation (which affects severity of illness ranking and reimbursement) when they are identified as not present on admission.

An example of a condition that is often present on admission, but frequently not documented by the resident or attending physician, are decubitus ulcers and other types of skin breakdown. It is especially important that these conditions be documented when the patient is transferred to UMDNJ from another institution of care and the condition is present on admission. These conditions should ALWAYS be identified in the Physical Exam and the treatment for such delineated in the treatment plan and orders.

**The physician’s role:**

Document, document, document some more! Thorough documentation can help to protect you, the facility and assure proper reporting affecting quality indicators, and reimbursement by showing which conditions were present on admission.

**Where to document conditions that are present on admission:**

**H & P** - this document is the initial assessment summary used to coordinate all care rendered to the patient. Conditions that are present on admission should be identified in the Chief Complaint and Medical History and Physical Exam sections. Be sure to indicate if each condition is still present and/or being treated. Conditions currently present should be summarized at the end of the document in an Assessment/Plan section.

**Progress Notes** - update your Assessment/Plan daily and indicate any conditions that were present on admission but not previously documented vs. conditions that developed during an inpatient stay.

"The importance of consistent, complete documentation in the medical record cannot be overemphasized."

Harriet Weinglass recently joined the Office of Ethics and Compliance as the Document Improvement Specialist & Auditor. She is a Registered Health Information Administrator with over 14 years experience in the management of Medical Record departments in acute care facilities. Harriet can be reached at 2-8067 to answer any questions you have regarding medical record documentation and improvement and can provide education regarding documentation requirements to groups or individuals.

**The FAX about Patient Privacy and the Federal HIPAA Regulations**

Faxes can be used very effectively in health care to speed the communication of medical information. But with the advent of HIPAA regulations, many are gun-shy of faxing and some have just plain quit faxing anything with protected health information (PHI). If you are confused about what information is safe to fax, and what is not, below you'll find information that will help you.

Doctors, labs, and other providers may fax patient information for treatment, payment or routine business operation (TPO) purposes. This does not require special patient authorizations as long as reasonable safeguards are used.

**Reasonable safeguards include:**

- Position the fax machine in an area that is secure or that is constantly staffed by authorized personnel. It should never be located in a hallway or other space easily accessed by unauthorized people.

- Don’t leave outgoing faxes containing PHI unattended.

HIPAA does not specifically require the use of a fax cover sheet or a disclaimer statement but we believe that a fax cover sheet should be used. It is sensible to use a cover sheet including a disclaimer as you are required to take appropriate steps to protect the privacy of all PHI. A disclaimer usually instructs the person on the other end who picks up the fax to deliver it immediately to the intended fax recipient without reading the contents of the fax. It further states that if the fax was sent to the wrong recipient, it should be destroyed without reading it. Some disclaimers also ask the recipient to contact the sender if the fax ended up with the wrong recipient.

- Limit the information provided by fax to the minimum necessary for the TPO purpose.

If you have a question about whether you can fax patient information somewhere, contact your Medical Records department or the Compliance Officer for your Operating Unit. We are here to help.
Coding Tip Of The Day

**Human Immunodeficiency Virus (HIV) Infections:**

**Coding Guidelines Addendum**—Inpatient and Outpatient Effective: 3/03.

This policy applies to the documentation and coding of HIV and is in accordance with the AHA Coding Clinic guidelines of the 1994 Fourth Quarter.

Patients with any known prior diagnosis of an HIV-related illness should always be coded to 042. Once a patient has developed an HIV-related illness, the patient should always be assigned code 042 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (042) should never be assigned to 795.71 or V08.

**Code V08,** Asymptomatic human immunodeficiency virus (HIV) infection, is applied when the patient is without any documentation of symptoms and is listed as being “HIV positive,” “known HIV,” “HIV test positive,” or similar terminology. Do not use this code if the term “AIDS” is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use 042 in these cases.

In cases where the physician has not documented AIDS for patients that have HIV-related illness with no prior history of AIDS, the coder will process a "physician query form" for clarification.

All disputable cases are to be referred to the Data Quality Manager in the Medical Records Dept. at 973-972-7640 http://www.umdnj.edu/uhcomweb/html/medrecords.htm

Thank you to Irene Szczezek and Susan DeSantis for providing information about POAs and coding tip for this article.


Future handouts will be provided about this subject.

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**Documentation and Coding of Late Effects**

Documentation of Late Effects can be confusing. What constitutes a late effect? How much time must pass before it is considered a Late Effect? Here are some tips to aid in distinguishing what constitutes late effects and how late effects should be documented.

A Late Effect is a condition or problem that is a direct result of a previous illness or injury. Late Effects have no specific time frame. However, coding guidelines do define Late Effects as a “residual effect (or condition produced) after the acute phase of an illness or injury has terminated”.

Frequent injuries, illnesses or conditions that may produce Late Effects are:

- Open Wounds
- Cerebrovascular Accidents
- Adverse reactions to Drugs, Surgical Complications and Misadventures do not have Late Effect codes.
- When documenting Late Effects, there are key statements that coders look for in diagnostic statements. Some of these key phrases are “caused by”, “due to” and “as a result of”. These phrases say to the coder, “something else is going on here, I may need two codes”. This is what we want to happen. Without these key phrases, meaning your reference to the original condition, Late Effects codes may be missed altogether. Documentation of the current condition as well as the cause of the condition is instrumental in appropriate coding. Additionally, in circumstances of injury or poisoning, indication of the circumstances of the injury or poisoning is necessary for the coder as well. With all of this information properly documented the coder can “tell the story” to the payer of what the patient is being treated for, why the condition arose and how the condition occurred.
- With all of this appropriate documentation, the coder will then follow the guidelines that state the primary code would be the residual condition that you are treating and the secondary code would be the Late Effect code, indicating the cause of the condition being treated. In the instance of a Late Effect that includes the manifestation, only one code would be used. These Late Effect codes can be found in the ICD-9-CM codebook, Volume 2, under the main term “Late”. The coder will also be able to apply an additional E-code in instances of injury or poisoning that describe the circumstances of the injury or poisoning. The coder will know via the guidelines that the code for the acute phase of (or the original) condition that produced the Late Effect should never be used in conjunction with a Late Effect code.

An example of Documentation and Coding for Late Effects is as follows:

**Documentation:** Gait disturbance due to previous fracture of tibia sustained in an MVA

**Correct Coding:** 781.2 (abnormality of gait); 905.4 (late effect of fracture of lower extremities); E929.0 (late effects of motor vehicle accident)

**Additional Information:**

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If you have any news that you would like included in the newsletter, please forward to:

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