Compliance Web Wednesday Newsletter

Montefiore Medical Center
Office of Corporate Compliance

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ICD-9-CM Codes Updated October 1, 2002 (Part A and Part B)

Part A Providers:
Effective on or after October 1, 2002, Medicare Services will begin accepting the new ICD-9-CM codes for diagnosis and procedures for hospital discharges and outpatient services. The new Grouper 20.0 will assign diagnosis related groups based on new codes. The Medicare code editor (MCE) 19.0 and outpatient code editor (OCE) 3.2 will use the codes in validating coding for discharges and outpatient services beginning October 1, 2002, or later. It is extremely important for you to use the most recent version of the ICD-9-CM coding book and code your diagnosis to the highest level of specificity.

Part B Providers:
All Medicare contractors will update their claims payment system on October 1, 2002, with the updated ICD-9-CM codes. There is a 90-day grace period between October 1, 2002, and January 1, 2003, during which Medicare will allow claims to be submitted with the 2002 and the 2003 ICD-9-CM code versions. However, claims for dates of service on or after January 1, 2003, must include the latest version (2003) of the ICD-9-CM codes.
Please remember that, effective October 1, 2002, ICD-9-CM coding validity will be determined by the date of service rather than the date the claim was submitted. This means that the ICD-9-CM code indicated on the claim must be an ICD-9-CM code that was valid at the time the procedure/service was performed. It is also extremely important for you to use the most recent version of the ICD-9-CM coding book and to code your diagnoses to the highest level of specificity.
(www.cms.hhs.gov/medlearn/icd9code.asp)

Serving Up your Cup Of Compliance News — From Zameena Rasheed - 718-920-2303
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Inside this issue:

CMS To Enforce HIPAA Transaction and Code Set Standards

HHS Secretary Tommy G. Thompson announced today that the Centers for Medicare & Medicaid Services (CMS) will be responsible for enforcing the transaction and code set standards that are part of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

"HIPAA administrative simplification is going to streamline and standardize the electronic filing and processing of health insurance claims, save money and provide better service for providers, insurers and patients," Thompson said.

"To accomplish this will require an enforcement operation that will assure compliance and provide support for those who file and process health care claims and other transactions," Thompson said. "CMS is the agency best able to do this."

CMS will continue to enforce the insurance portability requirements of HIPAA. The HHS Office for Civil Rights (OCR) will enforce the HIPAA privacy standards. CMS and OCR will work together on outreach and enforcement and on issues that touch on the responsibilities of both organizations - such as application of security standards or exception determinations.

Ruben J. King-Shaw Jr., CMS deputy administrator and chief operating officer, said CMS will create a new office to bring together its responsibilities under HIPAA, including enforcement.

"Concentrating these CMS responsibilities in a new office with a single mission will give us the most efficient operation possible, while providing strong support for all our partners in the health care community," King-Shaw said.

The new CMS office will establish and operate enforcement processes and develop regulations related to the HIPAA standards for which CMS is responsible. These standards include transactions and code sets, security, and identifiers for providers, insurers and employers for use in electronic transactions. The office will report directly to the deputy administrator.
The office also will conduct outreach activities to HIPAA covered entities such as health care providers and insurers to make sure they are aware of the requirements and to help them comply.

Federal law requires most health plans, clearing houses, and those providers that conduct certain transactions electronically to be compliant with the HIPAA transactions standards by Oct. 16, 2002, unless they file on or before Oct. 15 for a one-year extension. Those who are not compliant and have not filed for the extension may be subject to statutory penalties. (The law gives certain small health plans until Oct. 16, 2003 to comply).

Enforcement activities will focus on obtaining voluntary compliance through technical assistance. The process will be primarily complaint driven and will consist of progressive steps that will provide opportunities to demonstrate compliance or submit a corrective action plan.
(http://www.hhs.gov/news). 10-15-02

Special points of interest:

- MMC Compliance Hot Line **1-800-662-8595**
- **Please Call Zameena Rasheed to schedule your HCCS Web-based Training**

U.S. Settles With Seven Hospitals - Files Complaints Against Four In Cardiac Devices Litigation

WASHINGTON, D.C. – The United States has settled with seven hospital defendants alleged to have improperly billed Medicare for medical procedures involving experimental cardiac devices, the Justice Department announced today. This latest group of settlements brings to over $40 million the total settlements collected in the nationwide cardiac devices false claims litigation. The Department also announced that the government has intervened and filed complaints against four other hospital defendants.

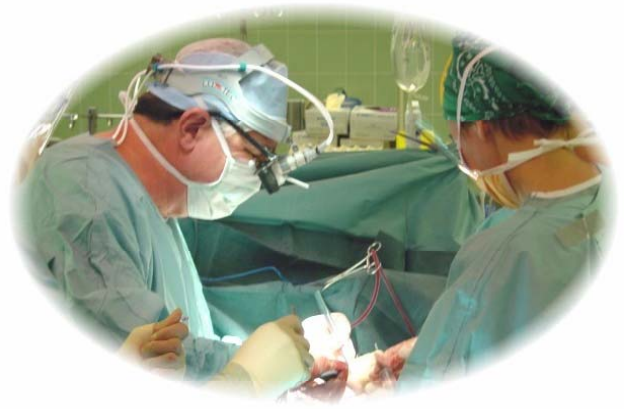
The suits allege that, between 1986 and 1995, the defendant hospitals unlawfully charged federal health care programs for medical procedures using experimental cardiac devices, which had not been proven safe and effective by the Food and Drug Administration, in violation of the False Claims Act. The case was originally brought by whistleblower Kevin Cosens, a former medical device salesman, against more than 100 hospital defendants.

The settlements announced today total more than $5.4 million. Beth Israel Deaconess Medical Center (formerly Beth Israel Hospital and New England Deaconess Hospital), a teaching hospital for Harvard Medical School, paid the United States $3.2 million. LDS Hospital in Salt Lake City, Utah, part of the Intermountain Health Care system, has agreed to pay $850,000. The General Hospital Center at Passaic and Hackensack University Medical Center, both located in New Jersey, paid the United States $760,000 and $314,000, respectively. Daniel Freeman Hospital in Los Angeles paid $250,000, and Good Samaritan Hospital of Santa Clara, also in California, paid $115,000.

The government and Mr. Cosens have previously settled with 22 other defendants and continue to pursue their claims against 46 hospital defendants. As part of the continuing litigation, the United States recently intervened and filed complaints against defendants Massachusetts General Hospital, Brigham & Women's Hospital and Lahey Clinic Hospital in Boston, As well as Hospital of the Good Samaritan in Los Angeles.

Under the False Claims Act, private citizens can bring suit on behalf of the United States and share in any recovery obtained by the government. Mr. Cosens will receive more than $1 million of the settlements announced today.

The government's investigation of the settled cases was conducted by the Justice Department's Civil Division; the United States Attorney's Offices in Boston, Massachusetts; Newark, New Jersey; Salt Lake City, Utah; San Francisco and Los Angeles, California; as well as the Office of Inspector General of the Department of Health and Human Services. (www.usdoj.gov)



New Inspector General of the Department of Health and Human Services

Janet Rehnquist was sworn in as Inspector General of the U.S. Department of Health and Human Services (HHS) on August 8, 2001. As Inspector General, Ms. Rehnquist is responsible for overseeing the work of the Office of Inspector General (OIG) through its audits, evaluations, civil and criminal investigations, and administrative authorities. Using these tools, the OIG is responsible for investigating and monitoring the Medicare and Medicaid programs as well as the over 300 other programs at HHS and its $429 billion budget. These activities help to ensure the cost-effective delivery of health care, improve quality of health care, and reduce the potential for waste, fraud and abuse.

Prior to joining HHS, Ms. Rehnquist served for several years as an Assistant United States Attorney General for the Eastern District of Virginia, where she focused on health care fraud enforcement. As an Assistant United States Attorney, she represented Federal courts and worked on a variety of matters, including those involving the False Claims Act and other health care enforcement statutes. **(http://oig.hhs.gov/organization/IGbiography.html)**

Department of Medicine Compliance Program….. *By* Chantal C. Volel

The associates in the Department of Medicine were pleased to have the occasion to meet with Zameena Rasheed from Compliance last week, at our monthly staff meeting. It was a very informative session and topics including Elaine Brennan's Customer Service Initiative and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations were discussed. The associates were given examples of issues that are received by Compliance and ways of preventing such issues from escalating within the department.

In addition, we discussed the PC Compliance training that is currently being conducted institution wide. MIS has been given the Workstation ID's for the associates PC's and will soon be installing Corporate Compliance software. Upon installation we will all be able to complete the training at our workstations. This training will assist the associates in the department in learning the necessary steps of Compliance within Montefiore. We are truly pleased for the opportunity to express our optimism about this program and look forward to the training.