Columbia University Medical Center
Office for Billing Compliance Manual
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I. OVERVIEW OF BILLING COMPLIANCE PROGRAM

A. Objective

The objective of the Columbia University Medical Center (sometimes referred to as “CUMC” or the “University”) Billing Compliance Program is to promote and ensure that the University’s affairs are conducted in accordance with applicable laws and regulations regarding professional fee billing. CUMC is dedicated to providing high quality medical education, research, patient care and service to the community. An integral part of this mission is the obligation of every member of the CUMC community, including each physician, non-physician practitioner (“NPP”) and staff member (and any affiliate or contractor corporation, organization or other entity, including any external billing company) that generates codes, submits, or is in any way involved in generating a bill for medical services, to act ethically and legally, and to document and bill for professional services appropriately and in accordance with applicable laws and regulations. Members of the CUMC community also are expected to respect private and confidential information and to adhere to laws and regulations governing the privacy and security of patient health information and billing for items or services furnished in connection with human subject research.

The University’s Billing Compliance Program is governed and guided by the CUMC Billing Compliance Plan and subject to applicable Federal and State Laws and regulations.

CUMC Billing Compliance Plan: The University’s Billing Compliance Plan has been in place since 1996. The Plan has been amended from time to time and reviewed periodically. The current version is available on the University’s Billing Compliance website: http://www.cumc.columbia.edu/dept/compliance. The University’s Billing Compliance Plan applies to: (1) all CUMC physicians, faculty and other health professionals involved in the provision of professional services (“CUMC clinicians”); (2) any persons, corporations, organizations or other entities, including external billing companies, who are involved in professional fee billing for CUMC clinicians (“billing personnel”); (3) any administrative personnel who are involved in implementing CUMC’s compliance efforts (“administrative personnel”); and (4) clinical research staff.

Federal and State laws and regulations: In addition to our Billing Compliance Plan, we are governed by a number of important laws and regulations, including Federal regulations for teaching hospitals; Federal and State fraud and abuse prohibitions, anti-kickback and physician self-referral laws; the Affordable Care Act, Federal and State False Claims Acts, including whistleblower protections; the Federal Deficit Reduction Act; and New York State Medicaid compliance program requirements.

This Billing Compliance Manual is intended to summarize, for easy use and reference, the compliance principles and organizational structure set forth in the Billing Compliance Plan and applicable Federal and State laws and regulations. The Manual is also intended to update, amplify and explain certain requirements and processes at the University, and to cross-reference
related legal and institutional requirements, including policies of ColumbiaDoctors.
https://secure.cumc.columbia.edu/columbiadoctors/op_policies.html

For additional information or to address specific compliance questions or concerns, contact the Office for Billing Compliance, **154 Haven Avenue, New York, NY 10032**, (212)305-3842, or the Office of the General Counsel, Columbia University, 535 West 116th Street, New York NY 10027, (212) 854-0287.
B. Organization

The University has designated certain individuals and offices to execute and oversee its Billing Compliance Program.

- **Chief Billing Compliance Officer:** The Chief Billing Compliance Officer is designated by the Executive Vice President and Dean of the Faculties of Health Sciences and Medicine. The Chief Billing Compliance Office has primary responsibility for implementation and managing the University's billing compliance effort, including but not limited to supervising audits, both internal and external, to evaluate compliance and assisting in addressing compliance issues that arise in the course of audits or otherwise.

- **Office for Billing Compliance (“OFBC”):** The University maintains an OFBC, which, under the supervision of the Chief Billing Compliance Officer and the Director of the OFBC: (1) assists in the review, revision and formulation of appropriate policies to guide billing of professional fees for services provided by CUMC clinicians; (2) reviews Federal and State Compliance Program Guidance, work plans, special advisory bulletins and special fraud alerts from the Health and Human Services Office of Inspector General (“OIG”) and the New York State Office of Medicaid Inspector General (“OMIG”) to identify risk areas and the need for changes in billing procedures; (3) works with the ColumbiaDoctors departments and CUMC clinicians to develop plans for implementing CUMC policies on billing; (4) develops and delivers billing-related educational training to University personnel; (5) coordinates review of medical charts and related billings; and (6) coordinates (with other departments, including the Office of the General Counsel) any repayments and other responses to identified billing issues; and (7) maintains compliance and refund logs.

The OFBC staff includes several managers (“Compliance Managers”), each of whom is assigned responsibility for the oversight of several clinical departments.

- **Departmental Compliance Personnel:** There are also compliance personnel within each clinical department. Each clinical department develops a work plan based on an annual departmental risk assessment and some large departments may develop plans for specific divisions. Each department appoints a faculty member and a departmental implementation plan administrator (collectively the “Departmental Compliance Leaders”), and some clinical departments have additional compliance staff members.

- **Office of the General Counsel:** The University’s Office of the General Counsel provides professional legal assistance and support for the Compliance Program, including involvement in responding to any identified problems/issues are identified.
• Privacy Office: Provides professional guidance and assistance in matters of privacy and related matters. The University maintains a Privacy Office, which includes a Privacy Officer and additional support staff. The Privacy Office is responsible for overseeing CUMC’s compliance with applicable privacy laws, rules and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder and the Health Information Technology for Economic and Clinical Health Act. Title XIII of the American Recovery and Reinvestment Act of 2009 and regulations promulgated thereunder ("HITECH").

• Office of the General Counsel: The University’s Office of the General Counsel provides professional legal assistance and support for the Compliance Program, including involvement in responding to any identified problems/issues are identified.
C. Scope

The Compliance Program set forth in this Manual and contained in the University’s Billing Compliance Plan applies to all CUMC clinicians, billing personnel, administrative personnel, and research staff, as applicable, and addresses billing for clinical activity by full-time and part-time CUMC clinicians for which professional fee revenues either flow through University accounts or are subject to an academic assessment by the University.

In addition, this Manual addresses policies on human subject research billing compliance, which extend to every member of the CUMC community.
D. Departmental Compliance Responsibilities

The Departmental Compliance Leaders’ responsibilities include: (1) monitoring compliance with the department compliance plan through routine reviews and departmental billing; (2) maintaining logs of billing or compliance issues that have been raised within the department, as well as the resolution of those issues, maintaining refund logs, and compiling annual compliance statistics for the OFBC; (3) providing billing-related education and training as necessary and ensuring that such education and training is received by the relevant individuals; (4) prepare annual department/division risk assessment; and (5) monitoring corrective action plans whenever compliance issues are identified.

Objective

To ensure that each clinical department addresses its compliance obligations.

Policy

Each clinical department must produce a risk assessment every two years to address compliance efforts on a departmental basis. Large departments may also choose to develop risk assessment for specific divisions. Before becoming effective, such department or division risk assessments must be reviewed by the Office for Billing Compliance to ensure consistency with overall CUMC policies.

Each department or division compliance responsibilities shall include the following features:

1. written policies and procedures for billing activities undertaken by department personnel;

2. risk assessment for identification of compliance risk areas specific to the department or division;

3. educational and training programs to address billing issues of particular importance to the department or division;

4. a program for ensuring, and documenting, that all new department or division personnel, including CUMC clinicians, billing personnel and administrative personnel, receive training with regard to proper billing and that all existing department or division personnel receive updated training with regard to proper billing as appropriate;

5. a monitoring plan to review compliance, with the results of such reviews being reported to the Departmental Compliance Leaders and to the OFBC;
6. review audit reports of department or division compliance statistics;

7. a plan for the use of compliance as an element in evaluating the performance of managers and supervisors who have responsibility for billing;

8. a program for developing corrective action plans when compliance issues are identified, including procedures for involving OFBC and/or the Office of the General Counsel when significant issues/problems are identified.

i. Record Retention

Objective

To ensure all clinical departments retain medical and financial records in an appropriate manner.

Policy

Patient medical records and related billing records shall be retained in their original or legally reproduced form for a period of at least six (6) years from the date of the patient’s last encounter or three (3) years after the patient’s age of majority (whichever is greater), unless otherwise required by any other University records retention policies or applicable statutes, rules or regulations.

Medical records and related billing records for patients who are mentally incompetent during any time they are treated shall be maintained in their original or legally reproduced form for a period of at least six (6) years from the date of the patient’s last encounter or three (3) years after the patient’s death (whichever is greater), unless otherwise required by any other University records retention policies or applicable statutes, rules or regulations.

These minimum periods for retention of patient medical records may be extended at the discretion of CUMC clinicians.
E. Code of Conduct for Billing Compliance

Objective

To obtain a written commitment from all CUMC clinicians and billing personnel, consultants, or contractors to act legally and ethically in furtherance of their work at CUMC.

Policy

All CUMC clinicians and billing personnel, consultants, or contractors are required to sign the CUMC Code of Conduct. Signed copies are maintained by the OFBC. The basic principles of the Code of Conduct are:

1. Be honest and ethical, which includes following ethical standards promulgated by applicable professional organizations. Treat all patients and their families with dignity and respect at all times.

2. Obey the law. If you are uncertain about what the law or applicable regulations require, seek assistance from your department’s compliance personnel or the OFBC, (212) 305-3842.

3. Be truthful. Document all care that you give timely, accurately, and completely.

4. Bills to patients and payors should reflect appropriate charges, be based on services actually provided, and be supported by documentation in the medical record.

5. Do not accept or pay kickbacks, or offer or accept any payment for referrals. Physicians must comply with applicable prohibitions on self-referrals.

6. Honor patient confidences. Patients rightfully expect that their private medical information will be handled appropriately and discretely. Confidential information concerning University matters also must be protected.

7. Report conduct that concerns you. If you believe that an activity may be illegal, unethical or otherwise troubling, report it. You may report to your Departmental Compliance Leaders, the OFBC, the Chief Billing Compliance Officer, or the University-wide compliance hotline, (866) 627-3768. There is a policy of non-retaliation for any good faith report of possible improper activity.

Enforcement: An individual’s failure to live up to these principles will result in disciplinary action, up to and including termination, consistent with University policy. For violations of applicable laws individuals may also face criminal and civil penalties, including monetary penalties. Failure on the part of the University to fulfill its legal obligations, including the
requirements of Federal health care programs, may result in exclusion from participation in such programs, as well as other criminal and civil penalties, including monetary penalties.
F. Columbia University Medical Center Hotline

Columbia University is committed to operating with integrity in full compliance with all applicable laws, regulations, and policies. The University sets expectations of the highest standards of ethical conduct and is committed to upholding its reputation as one of the top academic and research institutions in the world. The Compliance Hotline serves as a confidential channel for employees to report or seek guidance on possible compliance issues.

Columbia University relies on you to speak up if you believe that you have observed unethical, illegal or suspicious behavior. When you speak up, you provide the information necessary to investigate and remedy a potentially damaging situation. The University does not tolerate retaliation against individuals who report concerns in good faith.

For additional information, please refer to the Columbia University Non-Retaliation Policy.

Hotline - (866) 627-3768

Website: http://www.compliance.columbia.edu/hotline.html
G. Billing Compliance Website

The OFBC maintains a website that serves as a resource for billing and coding issues as well as OFBC policies and procedures. This website includes useful information such as:

- The Billing Compliance Plan
- The Billing Compliance Manual
- Online Compliance Training link. Available with e-mail invitation from Sight Training (University learning tool)
- The OFBC Staff List
- The Departmental Compliance Leaders List
- The Billing Compliance Hotline Numbers
- The New Hire and General Training information
- Links to relevant billing-related websites

The OFBC’s website address is: http://www.cume.columbia.edu/dept/compliance for additional information, the OFBC’s general phone number is (212) 305-3842.
II. COMPLIANCE OPERATIONS

A. Billing Compliance Risk Areas

Objective

To assist members of the CUMC community in preventing the submission of erroneous claims or engaging in unlawful conduct involving Federal and State health care programs.

Risk Areas

The Office of the Inspector General and Office of Medicaid Inspector General are responsible for protecting the integrity of Federal and State health care programs, including Medicare and Medicaid. To help health care providers prevent erroneous or unlawful claims for payment by these programs, the OIG and OMIG have identified risk areas where providers may be vulnerable to fraud and abuse. Such risk areas for physician practices include, among others:

1. Unbundling of services (billing for multiple components of a service that must be included in a single fee);
2. Billing for services not rendered or not provided as claimed;
3. Billing for non-covered services as if covered;
4. Submitting claims for items or services that are not reasonable and necessary;
5. Coding using one or two middle levels of service codes exclusively (also known as "clustering");
6. Upcoding the level of service provided;
7. Knowing misuse of provider identification numbers;
8. Double billing resulting in duplicate payment; and
9. Failure to properly use modifiers.

CUMC clinicians and staff shall not engage in such practices, which may result in serious consequences for the practitioner and the University, including monetary penalties, exclusion from Federal health care programs, and, under certain circumstances, criminal penalties.

A risk assessment by each department along with elements from OIG and OMIG is performed to assist departments in focusing on relevant compliance risks.
B. Risk Assessment Policy

**Objective** – To develop and implement an audit structure for the Office for Billing Compliance (“OFBC”) to better protect the University and its providers from non-compliant billing, ensure sound and correct billing practices and avoid unnecessary refunds of monies received. This structure is designed to provide assessments and auditing routines to capture compliance issues that may arise in a division or a department or the institution as a whole.

Summary of the audit structure:

1. Annual compliance provider audits scheduled after a risk assessment in each department by departmental compliance personnel with OFBC oversight. Annual audit shall consist of 25 services per provider and will include services of the type identified by the risk assessment and some services randomly selected for review. Any necessary subsequent follow up in education and re-audit will be completed. Providers will be audited each year.
2. An annual institution wide compliance risk based assessment will be conducted by OFBC to determine areas of practice and billing which pose significant risk. This risk assessment is in addition to departmental risk assessments described above and will focus on issues that affect the institution as a whole. Targeted audits or corrective actions will be a result of the assessment.
3. Research risk based assessment to be conducted by OFBC. The outcome of the assessment will set the research audit activity for the year.

**Annual Compliance Audits**

Utilizing MD Audit – Departmental compliance personnel will perform one annual audit per physician per year. The sample size will be increased to 25 patient claims based in part upon identified risk areas and some randomly selected, all billed within the prior 12 months. All other pass and fail requirements are unchanged for the annual audits. Meetings with Physicians, education sessions and re-auditing in 30 days will still take place as usual. Annual audits will be scheduled throughout the year (but after an annual risk assessment) to maintain year round auditing.

Reducing the compliance audit to once a year we will allow us to complete risk assessments for each department.

**Departmental and Divisional Compliance Risk Based Assessment**

A risk based assessment will be performed by each department. Departments with multiple divisions will most likely perform an assessment for each division. The outcome of the assessments will inform the audit activity for the year for that department or division. OFBC
will oversight the department risk assessment process and ensure that audits capture services within the designated and identified risk areas for the department, as well as some services selected randomly.

Recommended factors to be taken into consideration for risk assessment:

1. High volume billing
2. High volume billing of higher paid services
3. Departmental systemic failures (MD audit statistical failures)
4. Repeated individual physician failures and repeated education sessions
5. External audit activity – CMS, OMIG, and commercial, work plans for federal payor
6. Claims denial patterns
7. Top 20 CPT codes billed by volume and charge for both E&M and procedures
8. CPT changes to codes – new and modified (October of each year)
9. Medicare and Medicaid policy changes
10. Implementation of new programs, new ventures and processes with billing of services and codes

Process for Departmental Divisional Compliance Risk Based Assessment

1. Obtain information from MD Audit on your department’s statistical compliance percentage both by department and by individual physician.
2. Obtain a report of the top 20 CPT codes billed by volume for both E&M and procedures from your billing manager. Focus on high volume billing especially in the higher level codes or highly paid procedures.
3. Obtain claims denial reports for possible patterns
4. Review the OIG and OMIG work plans for relevance to your departments codes
5. Review code changes from October for your department
6. Review for policy changes from Medicare and Medicaid for codes utilized in your department

After the above information is gathered and reviewed it should be possible to identify risk areas.

Compliance Risk Based Assessment by OFBC- Institution-wide

A risk based assessment will be performed in aggregate for the FPO, Dental School, Nursing School by the OFBC once a year to be completed by the end of the first quarter of the year. The outcome of the assessment will inform the audit activity by the OFBC for the year for the entire institution.
The criteria for the assessment will be the same as above with an emphasis as how the data appears to affect the institution as a whole. This will be different than the departmental focus to some degree.

This risk based assessment will be completed by the central compliance office. The process is the same as the departmental assessments except the information gathered will pinpoint wider patterns and the risks could be different than that which is departmental based.

**Some factors to be taken into consideration for Risk Assessment – institution wide**

1. Departmental risk assessment results
2. Departmental systemic failures (Reflected in audit results)
3. Repeated individual physician failures and repeated education sessions
4. External audit activity – CMS, OMIG, and commercial
5. Claims denial patterns
6. Top 20 CPT codes billed by volume and charge for both E&M’s and procedures
7. CPT changes to codes – new and modified (October of each year)
8. Medicare and Medicaid policy changes
9. Implementation of new programs, new ventures and processes with billing of services and codes
10. Departmental Credit Balance statistics and creation rates
11. Acquisition of outside practices
12. MD Audit utilization by departments
13. NYF and CU shared personnel
14. ICD 10 readiness and transition
15. The Hotline
16. A confidential source
17. Departmental personnel
18. Patient complaints, and any other source from which comes an issue that affects the entire institution.
**Research Risk Based Assessment Institution**

A Research risk based assessment will be performed for the institution once a year by the OFBC. The outcome of the assessment will inform the research audit activity for the year for the entire institution.

**Criteria Research Risk Based Assessment**

1. Studies with a large volume of clinical services in the budget
2. Implantable device studies
3. Studies expected to have high enrollment number of subjects
4. Previous history of compliance concerns
5. No research coordinator or few study personnel associated with the study
6. New Investigators
7. Departments with large number of studies
8. Studies involving minors

**Process for Research Risk Based Assessment**

1. Obtain information from CTO/IRB, Rascal, study coordinators on the number of studies and categorize them into the criteria above
2. Review for studies that fit the criteria and choose a targeted sample of studies to review for the year
3. Review each study
C. Governing Laws and Guidelines

i. Prohibitions Against Kickbacks, Self-Referrals and Fee Splitting

Objective

To ensure that CUMC personnel comply with Federal and State law regarding kickbacks and self-referrals, and University rules regarding conflicts of interest.

Policy

CUMC personnel will not engage in activities that violate the Federal and State laws regarding kickbacks and self-referrals (prohibitions relating to the submission of false claims are addressed in the next subsection of this Manual). In addition, in order to avoid conflicts of interest, every year, each physician and NPP employed by the University will complete a University Conflict of Interest form, provided electronically by the University.

The following is a brief description of the Federal and New York State anti-kickback and physician self-referral laws. Because these descriptions do not encompass every applicable requirement, you should consult the OPBC for further guidance.

- **Federal anti-kickback law**: The Federal anti-kickback law provides criminal penalties for individuals and entities that knowingly offer, pay, solicit or receive bribes, kickbacks, rebates or other remuneration in order to induce or reward business that is reimbursable, in whole or in part, under a Federal health care program (including Medicare and Medicaid). The statute has been interpreted to cover any arrangement where one purpose of the remuneration (not necessarily the sole or primary purpose) was to induce referrals. Violation of the anti-kickback law is a felony, punishable by a fine of up to $25,000, imprisonment for up to five years, or both. Other possible penalties include the imposition of civil monetary penalties and exclusion from participation in Federal and State health care programs. Civil remedies may be imposed in an administrative proceeding, even in the absence of any criminal proceeding or investigation.

- **Federal physician self-referral law**: The Federal physician self-referral law, commonly known as the “Stark Law,” generally prohibits a physician from referring Medicare and Medicaid patients for certain “designated health services” (“DHS”) to an entity with which the physician (or a member of the physician’s immediate family) has a financial relationship, unless certain exceptions apply. The law also prohibits an entity from presenting or causing to be presented a bill to anyone for a DHS furnished as a result of a prohibited referral. The DHS covered by the law included, among other things, durable medical equipment and supplies, impatient and outpatient hospital services, and outpatient prescription drugs. Unlike the anti-kickback law, which requires a knowing intent, the Stark Law imposes a blanket prohibition on referrals for DHS between a physician and an entity with which the physician has a financial relationship, regardless
of the parties' intent. The penalties for violating the Stark law include possible civil monetary penalties and exclusion from the Medicare and Medicaid programs.

- **New York State professional misconduct and Medicaid anti-kickback laws:** Under New York State law, it is an act of professional misconduct for physicians and certain other health care practitioners to permit any person to share in, or to directly or indirectly request, receive, or participate in the division, transference, assignment, rebate, splitting or refunding of a fee for the provision of professional health care services ("fee-splitting"). Although physicians in private practice are entitled to purchase service from vendors at fixed, fair market fees, a physician could not, for example, pay a third party marketing firm a percentage of the physician's revenues or profits. Faculty practice arrangements are generally exempt from this prohibition, so University-employed physicians are permitted to share their professional fees with the University. Violation of this law may result in the revocation, suspension, or annulment of the practitioner's license, among other penalties. In addition, it is a crime for any New York State Medical provider to offer, solicit, give, receive, accept, or agree to give, receive, or accept any payment or other consideration, in any form, from any other person, for the referral of services, or to purchase, lease order any good, facility, service, or item for which Medicaid payment is made.

- **New York State self-referral law:** The New York State self-referral law generally prohibits physicians and certain other health care practitioners from making referrals for clinical laboratory, pharmacy, radiation therapy, physical therapy, or x-ray or imagining services if the practitioner or his or her immediate family has a financial relationship with entity providing there service, and from seeking payment for services provided pursuant to a prohibited referral.

For more information, please contact the OFBC at (212) 305-3842.

ii. **Detection and Prevention of Fraud**

**Objective**

To comply with Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), which requires that State Medicaid Plans be amended to require certain types of health care providers to establish written policies that address the following: (1) the Federal False Claims Act, 31 U.S.C. 3729-3733 ("FCA"); (2) the administrative remedies for false claims and statements found in the Program Fraud Civil Remedies Act, 31 U.S.C. 3801-3812; (3) State laws pertaining to civil or criminal penalties for false claims and statements; (4) the whistleblower protections provided under both Federal and State laws, and the role of these laws in preventing and detecting fraud, waste and abuse; and (5) the health care provider's policies and procedures for detecting and preventing fraud, waste and abuse.
Policy

Federal and State Laws Relating to False Claims and Whistleblower Protections

CUMC shall make available to all University faculty and staff written materials providing detailed information about the FCA and other Federal and State false claims laws and whistleblower protections by including summaries of those laws and protections in (1) Exhibit A to this Manual, and (2) any Employee Handbook published for employees of CUMC.

Policies and Procedures for the Prevention and Detection of Fraud, Waste, and Abuse

University policies and procedures that address the prevention and detection of fraud, waste, and abuse include, without limitation:

1. CUMC Billing Compliance Plan
2. CUMC Manual of the Office for Billing Compliance
3. Individual Department or Division Billing Risk Assessments

All CUMC faculty staff have an obligation to conduct themselves in accordance with all applicable laws and regulations, and to report actual or potential instances of fraud, waste, and abuse. Faculty or staff who have questions or concerns regarding the prevention and detection of fraud, waste, and abuse should consult with their respective Departmental Compliance Leaders or contact the OFBC at (212) 305-3842.

Reporting of Compliance Concerns

Any member of the CUMC community who knows or reasonably believes that the University or any of its employees or contractors may be involved in any activity that is prohibited by the FCA or other Federal or State fraud and abuse laws is required to immediately report such knowledge or belief using established University reporting procedures, which include reporting the matter to the Departmental Compliance Leaders, the OFBC, the Chief Billing Compliance Officer or the CUMC compliance hotline.

Non-Retaliation

The University will not take, or tolerate, any intimidating or retaliatory act against an individual because the individual, in good faith, makes a report of practices reasonably believed to be improper.

Compliance Monitoring

As detailed throughout this Manual, the University has established internal systems and controls to monitor its coding and billing practices on an ongoing basis to ensure compliance with FCA and other fraud and abuse laws.
iii. Physicians at Teaching Hospitals

Objective

To ensure that all services in which residents are involved are correctly billed in accordance with applicable rules and regulations regarding physician services in teaching settings. For purposes of this policy, a ‘resident’ includes a resident, intern, or fellow participating in an approved graduate medical education ("GME") program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. A “teaching physician” is a physician, other than another resident, who involves residents in the care of his or her patients.

Policy

Because we are an academic medical center and train and educate medical residents, we are governed by the Federal regulations concerning physician services in teaching settings (42 C.P.R. 415, Subpart D). Those regulations provide that, as a general rule, if a resident participates in a service furnished in a teaching setting, a teaching physician may receive payment for those services under the Medicare Physician Fee Schedule only if the teaching physician was present during the key portions of the service or procedure for which payment is sought. There are some exceptions to the general rule:

- In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire procedure. If circumstances present a teaching physician from being immediately available during a surgical procedure, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

- Minor procedures – For procedures that take only a few minutes (5 minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

- In the case of E/M services, the teaching physician must be present during the portion of the service that determines the level of service billed. However, in the case of E/M services furnished in hospital outpatient departments and certain other ambulatory settings, different requirements apply.

- Additional exceptions to the general rule apply for renal dialysis services, anesthesia services and psychiatric services.

In the case of E/M services, the teaching physician must personally document his or her participation in the service in the medical records. The teaching physician may not bill for his/her services based upon a countersignature alone, but must instead provide his or her own
written documentation. In order for a teaching physician to bill for his/her E/M services, the teaching physician must personally document at least the following: (1) that he or she performed the service or was physically present during the key or critical portions of the service when performed by the resident; and (2) the participation of the teaching physician in the management of the patient. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician. On medical review, the combined entries in the medical record by the teaching physician and resident constitute the documentation for the service and together must support the medical necessity of the service.

For CPT-4 codes determined on the basis of time, such as critical care codes, the teaching physician must be present for the entire period of time for which the claim is submitted. A combination of the teaching physician’s documentation and the resident’s documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician’s documentation may tie into the resident’s documentation. The teaching physician may refer to the resident’s documentation for specific patient, history, physical findings and medical assessment. However, the teaching physician’s medical record documentation must provide substantive information including (1) the time the teaching physician spent providing critical care; (2) that the patient was critically ill during the time the teaching physician saw the patient; (3) what made the patient critically ill; and (4) the nature of the treatment and management provided by the teaching physician.

iv. Speaking with Government Agents

Objective

To set forth CUMC policy and procedures regarding requests for information from Federal, State, or other government agents.

Policy

It is the policy of the University to cooperate with requests for information from governmental agents in accordance with applicable law.

Procedures

Interview Requests

If a government agent requests or initiates an interview with you:

1. Request identification and ask for a business card. It is important to have the name of the agent and the agency that he or she represents. If the agent does not have a business card, ask that the agent provide his or her contact information on a piece of paper.
2. A government agent may contact you by phone, letter, and/or personal visit to your office or home. Because proper identification cannot be obtained over the telephone, we suggest you defer and respond when the agent’s identity can be verified.

3. Do not feel intimidated or rushed by the agent. It is your choice entirely whether to speak with the agent.

4. If you do choose to speak with the agent:

   - It is the University’s preference that the interview take place in person, rather than over the telephone, and that a University representative be present. Accordingly, we request that you contact the Office of the General Counsel and the OFBC prior to your interview. It is appropriate to tell the agent that you will speak with him or her, but that you must first make the appropriate arrangements.

   - The University will provide you with legal representation for the interview, although depending on the nature of the interview and the matter, you may need to obtain your own counsel at some juncture.

   - No interview or discussion should take place in a patient care area or an area frequented by visitors.

**Search Warrants or Subpoenas**

If a government agent serves you with a search warrant or subpoena:

1. Request identification and ask for a business card.

2. Contact both the Office of the General Counsel and the OFBC. All search warrants and subpoenas must be directed to the Office of the General Counsel. However, you must comply with a valid search warrant even if it is served after hours, when you are unable to direct it to the Office of the General Counsel and the OFBC.

3. It is appropriate to ask that the agent write down exactly what documents are sought. Request a receipt for any documents that are taken. When possible, you should make a descriptive list of the documents.
Other Document Requests

If a government agent requests documents from you but does not serve you with a search warrant or subpoena:

1. Request identification and ask for a business card.

2. Contact both the Office of the General Counsel and the OFBC before providing the agent any documents.

In the event you are contacted by a government agent, the Office of the General Counsel, (212) 854-0287, and the OFBC, (212) 305-3842, are available to provide assistance.
D. Audit Policy

Objective

To ensure compliance procedures are followed across all clinical departments and to create an audit trail for billing compliance activity.

Policy

CUMC, through the OFBC and individual departments, will conduct the following types of audits.

1. Annual Audits – Conducted by each department as a matter of routine compliance activity and in accordance with each department’s risk assessment. These reviews are the subject matter of the quality assurance audits by the OFBC.

2. Sample Quality Assurance Audits – Conducted on an Annual basis by the OFBC Compliance Manager assigned to the individual department. The audit is conducted on services already reviewed as part of a department’s annual audits. If significant disparities exist between the results of the annual audits by the department and the quality assurance audit, the OFBC will require departmental personnel to attend billing compliance training as necessary and make other appropriate adjustments to the audit results.

3. Investigative Audits – Conducted by the OFBC and/or the Office of General Counsel when an issue is brought to the University’s attention or discovered during a routine review or quality assurance audit. Investigative audits can consist of a review of such documents as billing reports and medical records. Reports of Investigative Audit outcomes are shared with the Dean, the President of ColumbiaDoctors, personnel from the relevant department, and other appropriate parties at the University.

4. Pre-Billing Review Audits – Conducted on a special project basis as needed to review a physician’s audit statistics. Physicians achieving a high level of compliance with the pre-billing review audit may be transitioned to having their bills audited on an annual basis.

5. Federal or State Initiated Focused Audits – Conducted upon receipt of governmental requests for documentation or refunds. The OFBC will coordinate and assess all documentation to be submitted to the Federal or State government and will assist the relevant department in formulating a response to the audit.

6. Outsourced Billing and Coding Activity Audits – Conducted by OFBC on a regular basis to review a sample of documents coded by outside vendors. The OFBC shall
develop any necessary Corrective Action Plan, and departmental compliance staff shall conduct associated quality assurance monitoring and report the results of that monitoring to OFBC.

7. Research Billing Compliance Audits – Conducted by the OFBC on a regular basis to assess services for correct allocation of billing both to grants and to insurance companies.
E. Corrective Action Policy

Objective

To ensure that any instances of non-compliance with University policies or billing requirements are addressed and corrected in a prompt and appropriate manner.

Policy

At the discretion of the OFBC, any instance of non-compliance with University policies or billing requirements shall be addressed and corrected by a Corrective Action Plan formulated by the Chief Billing Compliance Officer. The OFBC will work with the appropriate Departmental Compliance Leaders to ensure that the plan is instituted and that the practice at issue is corrected. The Departmental Compliance Leaders are responsible for subsequent monitoring of the Corrective Action Plan and related activity within the applicable department(s) with timely reporting to the Chief Billing Compliance Officer and the OFBC.

1. Compliance issues identified by the OFBC, or by others and brought to the attention of OFBC, will be handled exclusively by the OFBC (unless involvement of the Office of General Counsel is appropriate) and will otherwise be subject to applicable University policy.

2. Typically, the OFBC will review the practices in question and, if appropriate, will formulate a Corrective Action Plan for immediate implementation. In most instances, the OFBC will meet with individual practitioners or staff involved and/or with departmental leadership and present the Corrective Action Plan. In some cases, a meeting may not be practicable, and the OFBC will present a written plan to departmental leadership in lieu of a meeting.

3. A Corrective Action Plan may include any or all of the following: (1) a period of pre-billing review of the relevant practitioner or department’s charges; (2) repayment of any associated overpayments; (3) retraining or re-education of practitioners and staff; (4) a written letter of warning or reprimand; (5) imposition of terms of probation; and/or (6) a recommendation of the restriction, suspension or termination of employment and/or University appointments, in accordance with University policy.

4. Employees also should be aware that the law may provide for monetary and criminal penalties.
F. Refunds /Credit Balances and Self Disclosures

Objective

To establish a standard operating procedure to manage credit balance accounts efficiently and to ensure that all refund balances are processed in a timely manner.

Management of Credit Balances and Timely Issuance of Refunds

All credit balances to be managed within 60 days of identification. Credit balances are monitored on a monthly basis by departments and ColumbiaDoctors, with credit balance oversight by the OFBC.

Policy

Patient Refunds

1. Patient refunds must be requested, authorized and vouchedered by separate staff under departmental supervision. Patient refunds must be issued through the University’s ARC system managed by the Controller’s Office. (Patient refunds via credit card are currently prohibited.) All refunds to be issued on a timely basis within 60 days of identification.

2. Patient refunds are mailed directly from the Controller’s Office except in cases where attachments are required. It is the responsibility of each department to ensure that all refunds are valid and accurate.

Credit Balance Refunds to Federal Payors

1. ACBM (Account Credit Balance Module) is used to gather credit balances from the IDX billing system and inserts the credit balances into federal payor files to be worked by the departments. These files are reviewed and adjudicated according to the findings of the review. If still a federal credit balance (Medicare or Medicaid) the files are compiled once a month and forwarded to the OFBC for review and submission of the refunds.

2. OFBC reviews the monthly files for Medicare and Medicaid credit balances and investigates any anomalies and requests checks from ColumbiaDoctors business office where appropriate. Upon receipt of the check OFBC submits refunds to the appropriate party.

3. Submitted files with check information are returned for debiting the accounts.
Credit Balance Refunds to Commercial Payors

1. ACBM is used to gather credit balances from the IDX billing system and inserts the credit balances into the commercial payor files to be worked by the departments. These files are reviewed and adjudicated according to the findings of the review. If still a commercial credit balance the approval process in ACBM allows the request for a refund check to go to the ARC system for processing and mailing.

2. Accounts should be debited as soon as a check is submitted to the Insurance company by ARC.

OFBC Oversight

Monthly analysis of the Federal and commercial credit balance reports is forwarded to the Dean’s Office.

Self-Disclosures

Self-disclosures are a type of refund. They occur either by discovery of an error in billing, overpayment due to a computer glitch (such as not appending the right place of service) that produces a refund that is not a credit balance in the IDX billing system. These are usually accounts paid in full with a zero dollar balance. The refund is due to another reason not immediately visible as a credit.

Medicare and Medicaid self-disclosures require a strict adherence to the individual federal payor’s protocol and process, such as the documentation with the required patient information that must accompany the self-disclosure and refund which can be specific and detailed.

Self-disclosures are handled by the OFBC working with the Department that has come across the issue. Departments have to charge correct the payment in IDX and prepare to request a check for the refund. OFBC gathers the finalized monetary information, patient identifiers, and the cover letter to submit with the check and the requested self-disclosure documents.

Files are kept by the OFBC as well as final disposition of the self-disclosure, with copies going to the individual department.
G. Education and Training Policy for Employees and Contractors Involved in Billing

i. Training for New Hires

Objective

To ensure that CUMC clinicians, billing personnel, consultants, or contractors (collectively, “billing personnel”), and administrative personnel receive timely billing compliance training.

Policy

New CUMC clinicians, new supervisors of CUMC clinicians, new billing personnel, and new administrative personnel are required to receive billing compliance training within thirty days of hire or engagement. This requirement is fulfilled by attendance at a one-hour New Hire Training session, or online via Columbia University training platform if approved by OFBC. New CUMC clinicians and billing personnel will not be permitted to use the central billing system until they have completed this training.

ii. Ongoing Training for CUMC Clinicians and Billing Personnel:

Objective

To provide CUMC clinicians, billing personnel and administrative personnel with current information on billing and coding and to fulfill the University’s obligations under its Compliance Plan and applicable regulations.

Policy

Each employee is responsible for fulfilling his or her ongoing billing compliance training requirements. The OFBC ongoing education and training program for CUMC clinicians and billing personnel requires them to attend one hour of education per year, which can be met by OFBC on line training via Columbia University training platform on specific coding and compliance issues, attending seminars hosted by the OFBC, or attending New hire training.

Contact the OFBC at (212) 305-3842 or its website at [www.cumc.columbia.edu/dept/compliance](http://www.cumc.columbia.edu/dept/compliance) for information.
iii. **Clearing Claim Scrubber Coding Edits in the IDX Billing System**

**Objective**

To establish responsibility and authority for clearing claim scrubber edits in the IDX billing system.

**Policy**

Claim scrubber edits in the IDX billing system are designed to help ensure the accuracy of claims for payment for health care items and services. A claim for payment will not be released until all edits are cleared. Edits may be cleared only by CUMC employees, contractors or consultants with the authority to do so, in accordance with this policy. In general, ICD-10 or CPT-4 coding changes should be made only: (1) by written confirmation of the provider; or (2) by a certified coder after review of documentation.

**Department/Division Responsibility**

Each department or division is responsible for assigning the proper personnel to clear IDX billing system edits according to the type of edit and any change that is required. Edits should be designated as requiring either billing staff or compliance staff clearance, and the work files containing such edits should be routed to respective personnel for appropriate clearance.

**Non-Certified Billing Staff or Manager Authority**

Non-certified billing staff or managers are authorized to clear:

- TES edits, which involve corrections in patient demographic information, physician names, and similar corrections.
- (Specific circumstance) If other (secondary) diagnosis codes were originally provided on charge ticket, one of these codes may be moved to the primary position. If only one diagnosis code is listed, new diagnosis code must be provided by Compliance personnel or the physician or NPP who furnished the service.
- (Type of edit): (Specific circumstance) May add modifier – 26 to a code for the professional component of a service supplied in the hospital.

No other diagnosis codes, CPT-4 procedure codes or modifiers should be added, changed, or deleted by non-certified billing/coding staff. Non-certified billing or coding staff shall make inquiry of the physician or NPP who furnished the service, or of the certified coder/compliance personnel assigned to the respective department or division to confirm the coding corrections suggested by the Claims Scruber edit, and may change the ICD-9, ICD-10 or CPT-4 codes as needed to clear edits upon written response from the billing physician or NPP, or the department or division compliance personnel. If a physician or NPP does not respond to an inquiry in a
timely manner, non-certified billing staff or managers should inform their respective compliance personnel for resolution of the edit before the charge is released from Claim Scriber.

**Certified Coder Authority**

A certified coder is a person who has a current Certified Professional Coder ("CPC") or Certified Coding Specialist – Physician-based ("CCS-P") certification. For purposes of this policy, Billing Managers or Medical Billers with at least 3 years coding experience and ongoing quality assurance review by a CPC/CCS-P certified coder may be considered certified coders. Compliance personnel who are certified coders have been assigned to each department or division.

Certified coders are authorized to clear:

- Any Claims Scrubber software edits for ICD-9, ICD-10 or CPT-4 coding changes, following review of relevant documentation.

  iv. **Qualification Standards for Charge Review Personnel**

**Objective**

To ensure that personnel hired to review diagnostic and procedural coding and other information to be included in claims for payment for health care items and services ("charge review personnel") are adequately educated and trained.

**Policy**

All charge review personnel must have a basic understanding of the following:

- Medical Terminology
- Documentation Standards
- International Classification of Disease (ICD) – ICD-9 & ICD-10
- Use of Modifiers
- Regulatory Compliance

All charge review personnel must demonstrate competence in these areas to the satisfaction of the Departmental Compliance Leaders in conjunction with the OFBC.
All charge review personnel must be provided with regular training and education opportunities both internal and external.

- All charge review personnel should attend a compliance training session as a new hire employee and every year thereafter.
- All charge review personnel must obtain professional certification as a CPC or CCS-P within two years of hire, and must maintain that certification throughout the course of their employment as charge review personnel at CUMC.

v. Policy Regarding Ineligible Persons

Objective

To ensure that the University does not employ or engage as contractors any individuals or entities who are excluded from participation in Federal or State health care programs ("Ineligible Persons").

Policy

CUMC will not employ, execute contracts with, provide items or services at the direction or prescription of, or use services provided by, Ineligible Persons.

The Federal and State governments, primarily through the OIG and OMIG, have the authority to exclude individuals and entities who have engaged in fraud or abuse from participation in Medicare, Medicaid, and certain other Federal and State health care programs. Exclusion from participation means that no payment may be made by those programs for any items or services furnished, directed, or prescribed by an excluded person. The prohibition against program payment also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to program beneficiaries. For example, this would include payment of the salary of a billing employee who has been excluded.

Health care providers or entities that employ or enter into contracts with excluded individuals or entities for the provision of items or services to program beneficiaries may be subject to civil entities for the provision of items or services to program beneficiaries. They may be subject to civil monetary penalties in excess of $10,000 for each item or service furnished by the excluded individual or entity and listed on a claim submitted to Medicare, Medicaid, or certain other Federal or State health care programs, if the health care provider or entity knows or should know that the person was excluded. In addition, the health care provider or entity could be assessed up to three times the amount or reimbursement claimed on all services furnished or ordered by the excluded individual, and could itself be excluded from program participation.
Individuals and entities can be excluded from program participation for many reasons, including, among others, conviction of a program-related offense, license revocation or suspension, and default on health education loans. Several government agencies have exclusion lists available to the public. The OIG maintains a List of Excluded Individuals/Entities ("LEIE"), available at http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html. The OMIG (Office of Medicaid Inspector General), also maintains an Excluded Parties List System, available at http://www.omig.ny.gov/fraud/medicaid-terminations-and-exclusions. The General Services Administration (GSA) similarly administers an Excluded Entities List System, which contains debarment actions taken by various Federal agencies, including exclusion actions taken by the OIG. The GSA's exclusion list can be accessed at: http://www.epis.gov. In addition, the New York State Office of Professional Misconduct ("OPMC") maintains a list of physicians who have been disciplined by the OPMC, available at http://www.health.state.ny.us/nysdoh/opmc/main.htm.

Procedures

The following are required procedures for prospective new hires and current employees, including contractors, respectively:

New Hires:

CUMC practice is for OFBC to screen all prospective new hires, including but not limited to, clinical staff, management and officers in the departments and administrative groups, management and ancillary staff at the 51st street site and other sites, Service Corporation, casual temporary employees in the clinical departments, and contractors, against exclusion lists maintained by the OIG and OMIG prior to the commencement of employment.

Upon notification of an impending new hire, the OFBC will search for the individual or entity on the OIG, OMIG lists. If the search results are POSITIVE, the OFBC must notify the hiring contact by email that this individual or entity may not be hired or otherwise engaged by CUMC.

Regular Review of CUMC employees and contractors

The OFBC oversees the regular screening of CUMC employees and contractors against the OIG and OMIG Exclusion List and the lists maintained by the GSA and the OPMC throughout the year.

1. The OFBC provides lists of its employees and contractors to an outside company that screens them against applicable Federal and State lists of excluded or disciplined persons.

2. The outside company returns the results of its screening to the OFBC.

3. The OFBC reviews the results and takes appropriate action, consistent with University policy.
vi. Billing Consultants or Contractors

Objective

To ensure that any outside billing consultants or contractors are retained in accordance with University policy.

Policy

The Chief Billing Compliance Officer must review and approve in advance any department’s engagement of outside billing consultants or contractors (including any individuals or entities involved in billing, coding, collections or related activities).

Under CUMC policy, the University is prohibited from hiring as an employee or engaging as a contractor any ineligible person. Accordingly, all individuals and entities engaged as billing consultants or contractors must be screened in accordance with Section II.G. i. of this Manual. In addition, all outside billing consultants must complete compliance training via CD audio in accordance with Section II G. vi. of this Manual.

Outside billing vendors that submit claims, check enrollment, or obtain authorizations must be enrolled as a "service bureau" in Medicaid. Also, billing vendors may not charge on a percentage of revenues or collections — they may charge fixed rates for their time or for each claim submitted (irrespective of amount).
III. MEDICAL BILLING GUIDELINES

A. Medical Billing Policy

Objective

To ensure that professional billing accurately reflects the services rendered, and that services rendered are appropriately documented and medically necessary.

Policy

1. CUMC clinicians must use their own billing IDs; they may not use others’ numbers when awaiting receipt of their own billing numbers.

2. Services rendered must be appropriate and medically necessary.

3. Medical records and related documents must be accurate and must clearly and legibly state what the CUMC clinician did, the correct date of service and the level of physician presence during all procedures. CUMC clinicians and billing personnel may not enter false information or ask anyone else to enter false information in medical records or related documents.

4. The integrity of the medical records and related documents must be protected. Records may not be backdated. Any amendment or addition of records must be in the form of a signed addendum with the current date (not the date of the earlier record).

   CUMC clinicians should use the active voice, rather than the passive voice, wherever appropriate, e.g. “I performed the endoscopy,” rather than the “the endoscopy was performed.”

5. Medical record entries must be prompt and made as close to the time of service as practicable.
B. Coding

Objective

To ensure that CUMC clinicians submit accurate diagnostic and procedure codes for services billed in their names. This coding policy applies generally to CUMC clinicians in most clinical departments. However, for some clinical departments, the OFBC has approved code selection using an abstraction method or similar process. In certain departments and divisions, non-physician coding may have been approved by OFBC and CUMC leadership.

Policy

1. With limited exceptions, each CUMC clinician is responsible for the CPT-4 and ICD-10 codes for services billed under his or her name and billing number. CUMC clinicians must be knowledgeable about the codes applicable to their practice.

2. The department compliance staff monitors whether the codes chosen match the medical record documentation for that code in order to ensure that accurate codes are billed.

3. The department compliance staff is responsible for notifying the CUMC clinician when there is possible discrepancy between the code chosen by the CUMC clinician and the staff’s determination of the appropriate code for the service. Such notification policies and processes are established by the routine auditing schedules for individual departments.

4. For Departments given permission for coders to review and select codes for the providers a routine audit by departmental compliance staff is required. These processes must be administered carefully and reviewed on a routine, consistent basis.

5. Departments that employ coders will direct their coders to share their coding findings with their departmental compliance staff on a regular basis.

6. Departmental coders are responsible for informing providers immediately of coding changes that involve an increase in reimbursement or additional revenue. Any increase in revenue, or up-coding requires the provider to give consent or acknowledgement to the change. However, insignificant changes not increasing revenue do not need notification.

**Examples of insignificant changes are:**

1. Reordering diagnosis for a more specific diagnosis in the first position on the claim
2. Consult conversion to an E&M when the consult code is not a code the insurance accepts
Examples of significant changes requiring immediate notification to the provider are:

1. A code selected by the provider and assessed by the coder as a level or two higher in the code category which will increase revenue.
2. A code added to the original code charged that increases revenue – E&M charged and a second code added such as prolonged services not previously selected by the provider.
C. **ICD-10 for diagnosis coding for services rendered after October 1, 2015.**

ICD-10 CM has replaced ICD-9 CM procedure codes and diagnostic codes in all health care setting for professional series rendered after October 1, 2015. [ICD-10-PCS will be used for facility reporting of hospital inpatient services]. Note that the change from ICD-9 to ICD-10 does not impact existing CPT/HCPCS coding systems. CPT and HCPCS coding will still be in use for professional services and procedures performed in outpatient facilities.

ICD-10 CM has many times the number of diagnosis and procedure codes than the ICD-9 system and will generally provide more detailed information and specificity about the patient and services than ICD-9. ICD-10 codes can have up to 7 rather than 5 alpha numeric characters, body laterality must be noted, if applicable, and whether a service is an initial or subsequent visit must be indicated within the code. Going forward, departments and clinicians will become familiar with a greater number of codes. Please note that provider documentation must support the more detailed ICD-10 code used. There are useful and informative websites for providers and staff. Call OFBC for further information (212-305-3842).
D. NPP (Non Physician Providers) Billing Practices

In addition to the general billing and coding policies addressed in Sections III.A, III.B and III.C of this Manual, the following policies may be applicable to services furnished by NPPs. There are three different ways that NPPs can receive reimbursement. These are direct billing of services, Incident to a physician’s service, and shared/split visit services with a physician.

Objective

To set forth the requirements for NPP billing for their services under the three models of reimbursement.

Policy

1. Direct Billing by Non Physician Providers (NPPs)

Professional services rendered by certain licensed non physician providers or NPPs may be billed directly to the Medicare program, provided that the services are within the NPP’s scope of practice, as defined by State law. NPP’s who are eligible for direct billing include, but are not necessarily limited to, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and Certified Nurse Midwives. In contrast, auxiliary personnel, such as most licensed and registered nurses and most technicians’, are not eligible for direct billing. NPP’s must be enrolled and receive their own provider numbers in order to directly bill services.

Reimbursement for Direct Billing of Services

Payment for NPP’s services is 80 percent of the actual charge, or 85 percent of the Medicare Physician’s Fee Schedule amount. NPPs may be employees or independent contractors of a physician or physician group practice, for the physician or group practice to bill for their services. PAs, may not bill their services directly to Medicare.

2. Incident to Billing by Non Physician Providers (NPPs)

Under certain circumstances, services furnished by NPPs may be billed under a physician’s provider number as “incident to” the physician’s services. To be covered as “incident to” the services of a physician, the services must be:

- An integral, although incidental, part of the physician’s professional service;
- Commonly rendered without charge or included within a physician’s bill;
- Of a type that are commonly furnished in a physician’s office or clinic; and
• Furnished under the physician’s direct supervision. Direct supervision requires the physician to be present within the office suite and immediately available to furnish assistance and direction throughout the service. The physician need not be present in the room with the patient and NPP during the service, but must be in the office suite and immediately available.

For a service furnished by an NPP to be covered as incident to the services of a physician, there must have been an initial first service, a direct, personal, professional service, furnished by the physician to begin the course of treatment of which the service being performed by the NPP is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician’s continuing active participation in and management of the course of treatment.

Services must be performed by an employee, leased employee, or independent contractor of the physician or an employee of the entity that employs the physician (thus, Columbia employed NPPs can provide “incident to” services for Columbia-employed faculty physicians).

Physicians are not required to countersign clinical notes entered by NPPs for claims submitted under the “incident to” provision for reimbursement reasons, but may be asked to do so for quality of care considerations. Documentation should contain evidence that the supervising physician was actively involved in the care of the patient and was present and available during the visit.

Unlike direct billing, an NPP need not have his or her own provider identification number in order for services furnished by the NPP to be billed as “incident to” a physician’s services.

Reimbursement for Incident to Billing

Services billed as incident to are billed under the Physician’s name and paid at 100% of the Medicare fee schedule.

3. Shared/Split Visits Billing

A shared/split E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision-making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared
E/M visit applies only to selected E/M visits and settings. The split/shared E/M policy does not apply to consultation services, critical care services or procedures.

Office/Clinic Setting: When an E/M service is a shared/split service between a physician and an NPP, the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. In this case, the service is reported using the physician’s unique physician identification number (“UPIN”) / provider identification number (“PIN”). If the requirements for “incident to” are not met, the service must be billed under the NPP’s UPIN/PIN.

Hospital Inpatient/Outpatient/Emergency Department Setting: When a hospital inpatient/outpatient or emergency department E/M service is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN. However, if there was no face-to-face encounter between the patient and the physician, the service may only be billed under the NPP’s UPIN/PIN.

Examples of Shared Visits:

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, either the physician or the NPP may report the service.

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the “incident to” requirements are met, the physician reports the service. If the “incident to” requirements are not met, the service must be billed using the NPP’s provider identification number.

Reimbursement for Shared/Split visit Billing
These services will be reimbursed according to the billing provider. If the NPP billed the services it will be 85% of the Physician’s fee schedule. If billed by the physician it will be reimbursed at 100% of the Physician’s fee schedule.

Other Providers:

For practice information on other providers such as Certified Registered Nurse Anesthetists and Anesthesiologist Assistants, Nurse Specialists, please see the CMS website for detailed practice information.
E. Diagnostic Supervisory Regulations

Objective

To apprise CUMC clinicians, billing personnel and administrative personnel of the Medicare rules regarding supervision of diagnostic tests.

Policy

In order for a diagnostic test to be payable under Medicare, it must be ordered by the physician that is treating the patient and, with certain limited exceptions, must be furnished under the appropriate level of physician supervision. Medicare regulations establish three levels of supervision required for furnishing and billing the technical component of diagnostic tests for a Medicare beneficiary who is not a hospital inpatient or outpatient.

1. **General Supervision**- The procedure is performed under the physician’s overall direction and control. They physician does not have to be physically present for the procedure. The training of the nonphysician personnel performing the procedure and the maintenance of the necessary equipment and supplies are the responsibility of the physician.

2. **Direct supervision**- The physician must be present in the office suite and immediately available for assistance and direction throughout the performance of the procedure. The physician does not have to be in the room during the procedure.

3. **Personal supervision**- The physician must be in the room during the performance of the procedure.

The code for each diagnostic test specifies the required level of supervision. For more information, or if you would like a copy of the codes and the corresponding supervision levels, please call the OFBC at (212) 305-3842.
F. Scribes

Objectives:

To apprise CUMC clinicians of the regulation and documentation requirements when using a scribe to document their patient visits.

Policy

When an ancillary or other staff member is documenting services performed by the physician, the ancillary or staff member is acting as a scribe. NP's or PA's may not act as scribes if they provide any portion of the service.
The scribe is present during the encounter and records in real time the actions and words of the physician as they occur. Scribes may not interject their own observations or impressions into the medical record. Physicians may rely on the review of systems (ROS) and past, family social history obtained and recorded by ancillary personnel.
The physician is responsible for all documentation and must verify that the scribe’s note accurately reflects the service provided.

Scribe documentation requirements:

The personnel scribing for the physician should sign as the scribe and the physician should sign the note as well as referencing the work of the scribe but stating that he/she performed the service.
A scribed note must include a personal note from the scribe that he/she was acting as a scribe on behalf of a physician.

Example:

I (scribe name) am acting as a scribe for Dr. (physician name) on (date).

Scribes Signature

Provider documentation Requirements:

A signed attestation by the provider indicating that the note accurately reflects the provider’s personal service and that it was scribed on his/her behalf.

Example:

I Dr. (physician name), obtained the HPI, performed the exam and formulated the decision making. I have edited the note which was scribed for me by (scribe name).

Provider Signature
IV. DOCUMENTATION AND EMR GUIDELINES

ColumbiaDoctors policy on the use of the Electronic Medical Record

Purpose:

The purpose of this policy and procedure is to establish the requirements regarding electronic documentation in our ambulatory electronic health record (EHR) called CROWN.

Following the principles below will help to ensure accurate and effective documentation practices that serve our patients well, enable robust communication and care coordination and are considered best practices for risk management purposes.

Background:

Creating an electronic medical record that facilitates excellence in patient care, meets regulatory requirements (such as billing compliance) and constitutes an accurate legal record for risk management purposes requires attention and vigilance. Legal, ethical and billing compliance principles that apply to electronic documentation are no different than those governing traditional handwritten notes. However there are two fundamental differences between the paper record and the EHR. First, EHRs have built in “support tools” like Copy Forward that can be simultaneously helpful and potentially problematic. Second, EHRs provide audit logs that can support review of the record.

Policy & Procedure:

1. Effective Clinical Communication:
   a. Notes should be concise, accurate, well-formed and easy to read.
   b. Notes should emphasize what took place on the day of service.
   c. Special emphasis should be placed on the Discussion and Plan portions of the note to clearly communicate the clinical reasoning behind the plan for diagnostic work up or pros and cons of particular treatment decisions.

2. Use of Electronic Documentation Support Tools (e.g. Copy/Paste, Copy Forward):
   a. “Copy and Paste” and “Copy Forward” should be used with extreme care.
   b. Wholesale copying and pasting text without attribution from another provider (most egregiously, another’s History of Present Illness (HPI), but including, for example, a radiology report without attribution) must be avoided.
c. It is acceptable to copy forward lists (e.g. problems, allergies, medications, social history items, health maintenance, immunizations) as long as they are always reviewed and updated and do not clutter the note. Bringing forward previous history critical to longitudinal care is encouraged, so long as it’s always reviewed and updated. To copy forward other elements of history, physical examination or formulations should be avoided, as errors in editing may jeopardize the credibility of the entire note.

d. Copying and pasting wholesale laboratory and radiology reports should be avoided. Important results should be noted, interpreted, and any actions taken in relation to results should be documented. Wholesale importation of information readily available elsewhere in the EHR creates unnecessary clutter, and may adversely affect readability.

e. The bill submitted for each service should reflect what was done during that specific service.

3. Timeliness:

a. Timely completion of medical record entries is required. Attending linkage/attestation statements should be done within 24 hours of the resident note to which it is linked.

b. Practitioners should sign and finalize their notes within 24 hours of the service rendered. Transcriptions from dictations should be reviewed within 48 hours, followed by making the note “final.” Notes finalized (i.e. completed) after 48 hours from the service rendered may be considered non-compliant.

c. No charges should be submitted/billed without a signed note for the care that is being billed.

d. Practitioners should review their CROWN Task Lists for timely completion of “Sign Note” tasks.

4. Supervision & Ownership of Notes:

a. Practitioners are required to author their own notes. Multiple practitioners may co-author a given note in CROWN if they are jointly providing a given service, but the responsible attending physician must review, contribute his or her own content, and sign as the ultimate “owner” of each note for that attending physician’s patients.
b. Practitioners must not share passwords and nor edit or otherwise change the content of another practitioner’s EHR note if not involved in providing a particular service.

c. Attestation statements for some services are procedures require specific statements regarding attending presence or involvement. Physician extenders must be supervised. Documentation and any billing by physician extenders should be under the rules of “incident to” billing or under their own billing numbers. Practitioners should check with their billing compliance officer if they are not sure what is required.

d. Once a note is finalized, an addendum can be added to document additional clinical information, or further clarification of services rendered during the visit as appropriate.

5. Security & Privacy:

a. Notes must only be entered in the EHR. Other electronic outlets (e.g. Google Documents, Gmail, Evernote and other Cloud services) are not secure and do not protect patient privacy. They must never be used to author clinical notes. To do so violates HIPAA and other privacy regulations.

6. Compliance and Auditing:

a. All Health Record documentation can be read by others and audited, and should be written accordingly.
V. COMPLIANCE POLICIES

A. Collection of Health Insurance Co-payments, Deductibles, and Coinsurance

Objective

To set forth CUMC’s obligation to collect co-payments, deductibles, and coinsurance from patients.

Policy

Most healthcare insurance plans or policies require patients to share the cost of the health insurance benefit. Cost sharing is effectuated through the imposition of health insurance co-payments, deductibles and coinsurance. These cost sharing mechanisms are imposed by the individual insurance company and are part of the insurance company’s contract with the patient.

Routine or consistent waiver of the patient’s cost sharing responsibility is considered by government regulators and private insurers to be an abusive practice and may be seen as a violation of a private health care insurance contract (and, possibly, insurance fraud).

1. All co-payments, deductibles and coinsurance must be collected, to the extent feasible, at the time of service. See ColumbiaDoctors website for their policy regarding time of service collection.

2. If the patient’s share of the bill cannot be collected at the time of service, departments should make at least three documented attempts to collect following the visit.

3. The patient’s share of the bill should not be waived under a department’s financial hardship policy.

CUMC clinicians may waive their entire fee, including co-payments, by not billing for their services.
B Professional Courtesy

Objective

Policy

Professional and employee courtesy, once a common practice, is no longer permitted by CUMC. Professional courtesy is defined as the elimination, or write-off, of any invoice, charge, or billing balance.)
C  Advance Beneficiary Notices of Noncoverage

Objective

To ensure that CUMC clinicians provide Advance Beneficiary Notice of Noncoverage ("ABNs") to Medicare beneficiaries as required under Medicare regulations.

Policy

Medicare rules require that Medicare beneficiaries receive written notice before receiving certain services for which Medicare probably will not pay. An ABN is given before providing any service that could be deemed by Medicare to be not reasonable and necessary. An ABN generally is not required, however, for services that are never covered by Medicare, such as cosmetic surgery that is not required for the prompt repair of accidental injury or other medical necessity.

All ABNs must be given using standardized forms that meet Medicare requirements. Please contact the OFBC at (212) 305-3842 for copies of the appropriate forms.
D  Acceptance and/or solicitation of gifts or benefits from vendors, patients and others

Generally, CUMC providers and staff may not accept gifts or benefits from vendors, patients or others given because of the individual’s association with the Medical Center and intended for the individual’s personal use. This Policy is not intended to prohibit holiday gifts or similar gifts of modest value. An example of an acceptable gift to a provider or staff member from a patient or patient’s family would be a basket of fruit or flowers to be shared with others on the unit or in the office. However, gifts of cash or cash equivalencies such as gifts certificates from vendors or patients may not be accepted by CUMC personnel.

The acceptance and solicitation of gifts or benefits from vendors and patients must be consistent and compliant with all applicable federal and state laws. Please call OFBC if further guidance is required.
E Patient Financial Hardship

Objective

To provide an appropriate basis and method to reduce fees for patients who are uninsured or unable to afford CUMC professional services.

Policy

1. CUMC clinicians strive to provide the highest standard of professional services to patients without regard to their ability to pay.

2. If patients are eligible for Medicaid benefits, departmental staff should help them in the Medicaid enrollment process or direct them to others who can assist them.

3. Where patients (a) are unable to pay for services based upon financial need, such as no insurance coverage, income three times the Federal Poverty Level or less, or other financial hardship such as recent high medical bills for the patient or a dependent; and (b) are not eligible for Medicare or Medicaid, they should be offered an opportunity to pay lower fees or no fees for services based upon a pre-established sliding scale for professional fees.

4. To qualify for reduced or no fees, the patient must provide the department with written evidence of income and/or other financial hardships. Sources of verification of income include: tax returns, paycheck stubs, and W-9 statements. Sources of verification of other financial hardships include official physician bills and explanations of benefits ("EOBs"). High medical expenses or other financial hardship may also be documented by patient interviews and questionnaires. In this instance, the department may wish to obtain a current utility bill or other form of reliable documentation from the patient to verify the patient’s name and residence.

5. The patient’s ability to pay and the number of services that may be covered by the sliding scale may be determined for each episode of care, or for a predetermined number of services.

6. This policy must be applied in a uniform manner to all patients that request accommodation based on financial hardship; if the department utilizes the sliding scale for fees for some patients that request accommodation, it must do so for all qualified patients requesting accommodation. Consult your departmental administrators or the OFBC with any questions.

7. This policy does not permit waivers of co-payments or deductibles for insured individuals, and does not extend to issues of bad debt or contractual adjustments based on
managed care fee for service or unrelated administrative adjustments for individual circumstances.
Payment Accommodation Policy

Policy

To provide an appropriate basis and method to arrange payment plans for patients who do not qualify for reduced fees.

Policy

1. Where a patient is not a candidate for sliding scale fee reduction, but requires some accommodation with payment, a department may enter into an agreement with the patient to pay the department’s regular and usual fee over a period of time, rather than in one payment at the time of service.

Refer to ColumbiaDoctors Payment Accommodation Policy.
https://secure.cumc.columbia.edu/columbiadoctors/op_policies.html Under certain circumstances, where there is an outstanding self-pay account balance, and after the Department has undertaken significant efforts to collect, appropriate departmental personnel may wish to offer a discount to patient to resolve and settle the outstanding balance. This should occur only rarely and not as a matter of course. Departments should not settle on a discounted basis any co-payments or deductibles owed by insured individuals.

CUMC must be judicious in its collection efforts, and must take care to comply with applicable privacy laws.
VI. OTHER PRACTICE POLICIES

A. Patient Transportation Policy

Objective

To set forth CUMC policy regarding payment for patient transportation.

Policy

1. Where current patients are unable to provide transportation for themselves by public or
   private means, CUMC may pay for reasonable transportation to and from CUMC under
   the following circumstances only:

   a. The patient must initiate the request for transport services/assistance;

   b. Upon receiving a patient request for assistance, the referring physician or CUMC
      personnel will direct the patient to the CUMC Finance Office. The Finance Office
      will evaluate each request and approve transportation assistance in cases of
      demonstrated need, based upon a finding that:

      (i) The patient lives within CUMC’s primary service area, and

      (ii) The patient is unable to pay for his/her own transportation for financial
           reasons (the patient must meet the income/resource tests for assistance as set
           forth in the CUMC Revenue Management guidelines); and

      (iii) The patient demonstrates absence of regular and reliable alternatives (e.g., no
           reasonably available public transportation, and no friend/relative willing to
           transport the patient).

2. The transportation shall be by modest means only, such as taxi, van or routine car service
   (i.e., no limousines, ambulances).

3. The transportation shall be limited to transport to and from CUMC facilities only, and
   shall not include transport to or from any unaffiliated health care provider’s office or
   facility.

4. CUMC shall not advertise or market to prospective or current patients the availability of
   this transportation assistance.

5. Under no circumstances may CUMC or any referring physician claim such transportation
   costs on any cost report or claim for payment.
6. Under no circumstance shall anyone outside the Finance Office approve transportation assistance under this policy.

7. Transportation assistance preferably will be in the form of CUMC making direct payment to the taxi or car service. Cash reimbursements to patients are disfavored and must be supported by credible documentation (e.g., automated taxi receipts that are date and time stamped).

For purposes of this policy, “referring physician shall be defined as a physician affiliated with CUMC either as full-time faculty or as a member of one of its independent practice associations (“IPAs”).

For purposes of this policy, “current patients” shall be limited to those individuals who are presently under the care of a referring physician and who have already been referred to, or are being treated at, CUMC in connection with such referring physician’s care.

This policy shall apply to all academic or clinical departments, divisions, centers and institutes within CUMC.
B. No Show Charge Policy

Objective

To set forth CUMC policy with respect to charging patients who do not show up for scheduled appointments or who cancel scheduled appointments without adequate notice ("missed appointments").

Policy

CUMC clinicians may charge patients a fee for missed appointments only in accordance with the following policies and procedures:

1. The department or clinician group must establish a written policy on charging for missed appointments that is provided to all patients, and must notify patients in advance of any such policy and its effective date. The written policy must include a statement of the minimum advance notice necessary when canceling an appointment to avoid a missed appointment charge.

2. Policies on charging for missed appointments must be prominently displayed in every private office where the policy will be implemented.

3. Policies on charging for missed appointments must be applied equally to all patients. The policy of the Centers for Medicare and Medicaid Services ("CMS") is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that the physicians and suppliers do not discriminate against Medicare beneficiaries, but also charge non-Medicare patients for missed appointments.

4. A single, uniform charge should be established for all missed appointments. The amount that the clinician or clinician group charges for a missed appointment must apply equally to all patients. Exceptions to this policy based on patient financial need or otherwise, may be made only on a case-by-case basis in consultation with the OFBC.

5. The charge for a missed appointment is not a charge for a service itself, but rather is charge for a missed business opportunity. Accordingly, clinicians or clinician groups charging for missed appointments must inform patients of the amount of the charge and that the charge may not be submitted to their insurance, and that payment of the charge is the patient’s responsibility.

Procedures

1. Clinicians or clinician groups assessing missed appointment charges must not allow such charges to be swept into collection by the automatic CRO sweep process, because such charges are not for services provided to the patient.
2. Clinicians or clinician groups assessing missed appointment charges must utilize a prescribed financial service class ("fsc") and write-off codes. ColumbiaDoctors information system (CDIS) can assist with a code for both processes.
VII.  RESEARCH BILLING COMPLIANCE

Objective

To set forth compliance requirements for the medical billing of clinical services provided to subjects who participate in clinical trials or other human research studies in accordance with the Federal guidelines from CMS (http://www.cms.hhs.gov) and National Institutes of Health (NIH) (http://www.nih.gov); to help ensure that clinical services associated with research studies are not billed inappropriately or in duplicate to a patient or third-party payor; and to help ensure that the University adheres to all the regulations that govern medical billing practices in this area.

Policy

It is the policy of CUMC that faculty, providers and staff work together to ensure that clinical services associated with a research study are billed appropriately and in compliance with relevant laws and regulations. Any research related billing must be coded and charged based on actual services rendered; must be allowable by regulations governing medical billing practices; must be in accordance with the terms of any sponsored research project; and must be consistent with the informed consent signed by the research subject. As research billing is subject to the federal regulations, it falls under the University Billing Compliance policy.

Roles and responsibilities of OFBC

Education:

- Provide, and maintain procedures to enable compliance with regulatory requirements;
- Provide guidance to principal investigators, study coordinators, department administrators and other designees on topics encompassed in this policy and its related procedures;

Monitoring and Auditing:

- Design and conduct compliance reviews of services provided to study subjects in order to monitor compliance with this policy and applicable medical billing regulations;
- Conduct Research Billing Compliance Audits based on an annual research compliance risk assessment (See Section II.B of this Manual);
- Receive and monitor all investigations of potential non-compliance issues reported to the Research Compliance Office;

Research Risk Based Assessment
A Research risk based assessment will be performed for the institution once a year by the OFBC. The outcome of the assessment will set the research audit activity for the year.

**Criteria Research Risk Based Assessment**

1. Studies with a large volume of clinical services in the budget
2. Implantable device studies
3. Studies expected to have high enrollment number of subjects
4. Previous history of compliance concerns
5. No research coordinator or few study personnel associated with the study
6. New Investigators
7. Departments with large number of studies
8. Studies involving minors

**Enforcement:**

- Corrective action plans to address any instances of non-compliance with CUMC research related policies and with federal and state laws and regulations related to research.
VIII. HIPAA/HITECH COMPLIANCE

Objective

To safeguard the privacy of all patients and to protect the confidentiality and security of patient information.

Policy

To fulfill this responsibility and to comply with HIPAA, HITECH and other applicable laws and standards, CUMC has implemented policies and standard procedures to protect the confidentiality and security of individually identifiable protected health information ("PHI") in all of its activities that require the use and disclosure of PHI. These policies and procedures are posted on an internal HIPAA web site available at http://cumc.columbia.edu/hs/hipaalindex.html.

Additionally, CUMC has in place mandatory programs to provide training to all members of its workforce regarding its HIPAA policies and standard procedures. CUMC has a Privacy Office and employs a full-time Privacy Officer who is dedicated to the day-to-day administration of HIPAA compliance. To further facilitate these privacy compliance efforts:

1. All CUMC faculty are required to complete an annual web-based HIPAA training. Registration for this course (including your access ID) is obtained through the Privacy Office.

2. All research staff must complete the HIPAA training posted on the RASCAL database under the “testing center.” HIPAA research training is a pre-requisite to submitting a protocol for human subject research and provides instruction on the type of HIPAA forms needed to be filed for approval of research access to PHI. Researchers who also have clinical patient care responsibilities are required to complete both Rascal Research HIPAA and general HIPAA training.

3. All other CUMC personnel must complete annual general HIPAA training. The HIPAA training is given during CUMC new employee orientation.

4. Generally, vendor contracts that require the disclosure of PHI must have a Business Associate Addendum (BAA) included as part of the underlying contract. Certain exceptions may apply, but departments should obtain a signed BAA unless the Privacy Office given advance approval that a BAA is not necessary in connection with a particular arrangement.

5. All patients visiting CUMC for the first time must receive a hard copy of the CUMC Notice of Privacy Practices, which describes the patient’s HIPAA rights and the policies...
and practices of CUMC with respect to the use and disclosure of the patient’s PHI. The patient is asked to sign an acknowledgement form when receiving the Notice of Privacy Practices, and that signed acknowledgment form must be placed in the patient’s medical record.

6. The administration and investigation of all patient complaints made with respect to the privacy of their PHI are handled by the Privacy Officer. If you are approached by a patient with a privacy complaint, call the Privacy Officer at (212) 305-7315. All patient privacy complaints are handled discreetly and are thoroughly investigated, resolved and logged.

7. There is a zero tolerance policy on the abuse of privileges to access patient information and/or clinical databases electronically, and on the use of such information for purposes not related to treatment, payment or other authorized use. Audit trails record electronic access and are frequently reviewed. All users of electronic clinical information systems are expected to follow procedures related to security of electronic information including password protection, business need and other information security policies posted at http://cumc.columbia.edu/hs/hipaa.

8. Computer Security Reminders – The security of our shared systems requires that we all fully cooperate with the following basic measures. Failure to follow these requirements will result in disciplinary action.

   a. Do not share your user ID and password with anyone. You are responsible for all access activity after you sign on to an application.

   b. Audit reports can track what, when and where information is accessed based on your user ID. Do not sign on to a computer application and allow another person to access information or use the computer. All of the other persons’ work will appear in the audit log under your user ID. You are responsible for all information accessed with your user ID and password.

   c. Do not write down your user ID and password and leave it available at a work station, desk or other unsecured area.

   d. Always refuse to use another person’s user ID and password.

If you think someone may have had access to your user ID or password you are urged to contact the CUMC IT help Desk by calling 5-Help (5-4347, or 305-4347), or the administrator of the application you are using, and request that your password to be reset.
Please contact the following persons if you have questions about information security and privacy at CUMC.

Brian Sweeney,
Chief Information Security Officer,
CUMC bs2931@columbia.edu
212-305-212-342-0268

Karen Pagliaro-Meyer,
Privacy Officer, CUMC
kpagliaro@columbia.edu
212-305-7315
APPENDIX A

FEDERAL & NEW YORK LAWS RELATING TO FALSE CLAIMS

I. Federal Laws

A. False Claim Act (31 U.S.C. §§ 3729-3733)

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Liability for Certain Acts.

(1) In general, Subject to paragraph (2), any person who
    A. knowingly presents, or causes to be presented, a false or fraudulent
       claim for payment or approval;
    B. knowingly makes, uses, or causes to be made or used, a false record or
       statement material to a false or fraudulent claim;
    C. conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or
       (G);
    D. has possession, custody, or control of property or money used, or to be
       used, by the Government and knowingly delivers, or causes to be
       delivered, less than all of that money or property;
    E. is authorized to make or deliver a document certifying receipt of
       property used, or to be used, by the Government and, intending to
       defraud the Government, makes or delivers the receipt without
       completely knowing that the information on the receipt is true;
    F. knowingly buys, or receives as a pledge of an obligation or debt, public
       property from an officer or employee of the Government, or a member
       of the Armed Forces, who lawfully may not sell or pledge property; or
    G. knowingly makes, uses, or causes to be made or used, a false record or
       statement material to an obligation to pay or transmit money or property
       to the Government, or knowingly conceals or knowingly and
       improperly avoids or decreases an obligation to pay or transmit money
       or property to the Government,

Is liable to the United States Government for a civil penalty of not less
than $5,000 and not more than $101,000, as adjusted by the Federal
Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note;
Public Law 104-410)(note that after this inflation adjuster, the current
range of penalties is $5,500 to $11,000), plus 3 times the amount of
damages which the Government sustains because of the act of that
person.

(2) Reduced damages. If the court finds that
A. the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

B. such person fully cooperated with any Government investigation of such violation; and

C. at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation, the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions – A person violating this subsection shall also be liable to the United States Government for the costs of civil action brought to recover any such penalty or damages.

(b) Definitions. For purposes of this section

(1) the terms “knowing” and “knowingly”
   (A) Mean that a person, with respect to information
       i. Acts in deliberate ignorance of the truth or falsity of the information;
       or
       ii. Acts in reckless disregard of the truth or falsity of the information
   (B) Requires no proof of specific intent to defraud

(2) The term “claim”
   (A) Means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that
      (i) Is presented to an officer, employee, or agent of the United States; or
      (ii) Is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government
         (I) Provides or has provided any portion of the money or property requested or demanded; or
         (II) Will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and
   (B) Does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual’s use of the money or property;
(3) The term “obligation” means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment;

(4) The term “material” means having a natural tendency to influence, or be capable of the influencing, the payment or receipt of the money or property.

While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information also can be found liable under the FCA. 31 U.S.C. § 3729(B).

In sum, the FCA imposes liability on anyone who submits a claim to the Federal Government or submits a claim to entities administering government funds, which he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided (or with an intentional upcode). The FCA also imposes liability on an individual who knowingly submits a false record in order to obtain payment from the Government. An example of this may include a Government contractor who submits records that he knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements. A third area of liability includes those instances in which someone may obtain money from the Federal Government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. § 3730(b). These private parties, known as “qui tam relators” or “whistleblowers” may share in a percentage of the proceeds from a FCA action or settlement.

Subject to certain exceptions, section 3730(d)(1) of the FCA provides that when a qui tam relator brings a false claims act case on behalf of the government, and the Government later directly intervenes in (i.e., takes over) the lawsuit, a qui tam relator shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action, depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene (i.e., where the qui tam relator must fully litigate the case he or herself), section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable, which shall be not less than 25 percent and not more than 30 percent.

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This statute allows for administrative recoveries by federal agencies. If a person submits a claim that the person knows or has reason to know is false or contains false information, or omits material information, then the agency receiving the claim may impose a penalty of up to $5,000 for each claim. The agency also may recover twice the amount of the claim.

Unlike the FCA, the determination of whether a claim is false, and the imposition of fines and penalties is made by the administrative agency, not by litigation through the federal court system. Also, unlike the FCA, a violation of this law occurs when a false claim is submitted, rather than when it is paid.
II. NEW YORK STATE LAWS

New York's false claims laws fall into two categories: civil/administrative laws, and criminal laws. Some apply to recipient false claims and some apply to provider false claims. While most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. CIVIL AND ADMINISTRATIVE LAWS

1. New York False Claim Act (State Finance Law, §§ 187-194)

   The New York False Claims Act is similar to the Federal False Claims Act. It imposes penalties and fines on individuals and entities that knowingly file false or fraudulent claims for payment from the State or a local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000 - $12,000 per claim plus three times the amount of all damages that the state or local government sustains because of the act of the person. In addition, a person who knowingly files false claims may be required to pay the government's legal fees.

   As in federal False Claim Act cases, the New York False Claims Act allows private individuals to file lawsuits in State court on behalf of the people of the State or a local government. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25 – 30% of the proceeds if the government did not participate in the suit, and 15-25% of the proceeds if the government did participate in the suit.

2. Social Services Law § 145-b False Statements

   It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $10,000 per violation. If repeat violations occur within five years, a penalty of up to $30,000 per violation may be imposed if the repeat violations involve more serious violations of Medicaid rules, billing for services not rendered, or providing excessive services.

3. Social Services Law § 145-c Sanctions

   If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's needs or that of his or her family shall not be taken into account for the purpose of determining his or her needs or that of his or her family for six months if a first offense; 12 months if a second offense (or if benefits wrongfully received are at least $1,000, but not more than $3,900); 18 months if a
third offense (or if benefits wrongfully received exceed $3,900); and five years for any subsequent occasion of any such offense.

4. Executive Law § 63 (12)

If a person engages in repeated fraudulent or illegal acts or otherwise demonstrate persistent fraud or illegality in carrying on, conducting or transacting business, the attorney general may apply, in the name of the people of the state of New York, to the supreme court of the state of New York, on notice of five days, for an order enjoining the continuance of such business activity or of any fraudulent or illegal acts, and directing restitution and damages, and the court may award the relief applied for or so much thereof as it may deem proper. The word “fraud” or “Fraudulent” as used in this statute includes any device, scheme or artifice to defraud and any deception, misrepresentation, concealment, suppression, false pretense, false promise or unconscionable contractual provisions. The term “persistent fraud” or “illegality” as used in this law includes continuance or carrying on of any fraudulent or illegal act or conduct. The term “repeated” as used in this law includes the repetition of any separate and distinct fraudulent or illegal act, or conduct which affects more than one person.

B. CRIMINAL LAWS

1. Social Services Law § 145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

2. Social Services Law § 366-b Penalties for Fraudulent Practices

   a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.

   b. Any person who, with intent to defraud, presents for payment any false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation than that to which he is legally entitled, or knowingly submits false information in order to obtain authorization to provide items or services under the Medicaid program is guilty of a Class A misdemeanor.

3. Penal Law Article 155 Larceny

The crime of larceny is committed by a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. This law has been applied in Medicaid fraud prosecutions.
a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.

b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.

c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.

d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

4. Penal Law Article 175 False Written Statements

This Article contains four crimes that have been applied in Medicaid fraud prosecutions.

a. § 175.05. Falsifying business records involves entering false information, omitting material information or altering an enterprise’s business records with the intent to defraud. It is a Class A misdemeanor.

b. § 175.10. Falsifying business records in the first degree includes the elements of the § 175.05 offense and includes the intent to commit another crime or aid in or conceal its commission. It is a Class E felony.

c. § 175.30. Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to public office knowing that it contains false information. It is a Class A misdemeanor.

d. § 175.35. Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the State or any political subdivision. It is a Class E felony.

5. Penal Law Article 176 Insurance Fraud

This Article establishes criminal penalties for fraudulent insurance acts. It defines a fraudulent health insurance act to include, among other things, filing a health insurance claim for payment (including a Medicaid claim) knowing that it contains materially false information concerning any material fact, or conceals, for the purpose of misleading, information concerning any fact material to the claim for payment. The law contains six crimes.

a. Insurance fraud in the fifth degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.

b. Insurance fraud in the fourth degree is filing a false insurance claim for over $1,000. It is a Class E felony.

c. Insurance fraud in the third degree is filing a false insurance claims for over $3,000. It is a class D felony.

d. Insurance fraud in the second degree is filing a false insurance claim for over $50,000. It is a class C felony.
e. Insurance fraud in the first degree is filing a false insurance claims for over $1 million. It is a class B felony.
f. Aggravated insurance fraud is committing insurance fraud more than once within five years. It is a class D felony.

6. Penal Law Article 177 Health Care Fraud

This Article establishes criminal penalties for fraudulent requests for payment from a health plan, including Medicaid.

a. A person is guilty of health care fraud in the fifth degree when, with intent to defraud a health plan, he or she knowingly and willfully provides materially false information or omits material information for the purpose of requesting payment from a health plan for a health care item or service and, as a result of such information or omission, he, she or another person receives payment in an amount to which he, she or the other person is not entitled under the circumstances. Health care fraud in the fifth degree is a class A misdemeanor.

b. A person is guilty of health care fraud in the fourth degree when the person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the aggregate payment wrongfully received from a single health plan in a period of not more than one year exceeds $3,000. Health care fraud in the fourth degree is a class E felony.

c. A person is guilty of health care fraud in the third degree when the person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the aggregate payment wrongfully received from a single health plan in a period of not more than one year exceeds $10,000. Health care fraud in the third degree is a class D felony.

d. A person is guilty of health care fraud in the second degree when the person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the aggregate payment wrongfully received from a single health plan in a period of not more than one year exceeds $50,000. Health care fraud in the second degree is a class C felony.

e. A person is guilty of health care fraud in the first degree when the person, on one or more occasions, commits the crime of health care fraud in the fifth degree and the aggregate payment wrongfully received from a single health plan in a period of not more than one year exceeds $1 million. Health care fraud in the first degree is a class B felony.
III. WHISTLEBLOWER PROTECTION

A. Federal False Claims Act (31 U.S.C. § 3730(h))

The Federal False Claims Act provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by their employers because of lawful acts in furtherance of an action under the FCA or efforts to stop violations of the FCA. Remedies include reinstatement with the same seniority status the employee would have had but for the discrimination; two times the amount of any back pay; interest on any back pay; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.

B. New York False Claim Act (State Finance Law, § 191)

The New York False Claims Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment, or otherwise harmed or penalized by their employers because of lawful acts in furtherance of an action under the Act. Remedies include an injunction to restrain continued discrimination; reinstatement to the position the employee would have held but for the discrimination or to an equivalent position; reinstatement of full fringe benefits and seniority rights; payment of two times any back pay, plus interest; and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.

C. New York Labor Law § 740

An employer may not take any retaliatory personnel action against an employee because the employee discloses or threatens to disclose certain information about the employer’s policies, practices, or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law, rule or regulation, and that the violation creates a substantial and specific danger to the public health and safety or constitutes health care fraud under Penal Law § 177 (see above). The employee’s disclosure is protected only if the employee first brought the policy, practice, or activity to the attention of a supervisor and gave the employer a reasonable opportunity to correct the activity, policy, or practice. If an employer takes a retaliatory action against the employee, the employee may sue in State court for reinstatement to the same or an equivalent position, any lost back wages and benefits and attorneys’ fees. If the employer is a health provider and the court finds that the employer’s retaliatory action was in bad faith, the court may impose a civil penalty of $10,000 on the employer.
D. New York Labor Law § 741

A health care employer may not take any retaliatory action against an employee because the employee discloses or threatens to disclose certain information about the employer’s policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those concerning an employer policy, practice, or activity that the employee, in good faith, reasonably believes constitutes improper quality of patient care. The employee’s disclosure is protected only if the employee first brought the alleged improper quality of patient care to the attention of a supervisor and gave the employer a reasonable opportunity to correct the activity, policy, or practice, unless there is an imminent threat to public health or safety or to the health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in State court for reinstatement to the same or an equivalent position, any lost back wages and benefits and attorneys’ fees. If the court finds that a health care employer’s retaliatory action was in bad faith, the court may impose a civil penalty of $10,000 on the employer.
APPENDIX B
FREQUENTLY USED TERMS

Billing Compliance Plan
The University’s Billing Compliance Plan, in place since 1996 and periodically amended, addresses billing for clinical activity by full-time and part-time CUMC clinicians for which professional fee revenues either flow through University accounts or are subject to an academic assessment by the University.

Centers for Medicare and Medicaid Services (“CMS”)
Agency within the United States Department of Health and Human Services that administers the Medicare, Medicaid, and State Children’s Health Insurance programs.

Concurrent Care
See section III.E. of this Manual.

CPT-4
Current Procedural Terminology, 4th Edition (“CPT-4”) is the coding system used by Medicare, Medicaid, and private payers to describe medical, surgical, and diagnostic services.

Department of Health and Human Services (“DHHS”)
The United States government’s principal agency for protecting the health of all Americans and providing essential human services; DHHS agencies include the Office of Inspector General and the Centers for Medicare and Medicaid Services.

ICD-9/ICD-10 Codes
ICD-10 CM is scheduled to replace ICD-9 CM procedure codes and diagnostic codes in all health care setting for professional series rendered after October 1, 2015 [ICD-10-PCS will be used for facility reporting of hospital inpatient services]. Note that the change from ICD-9 to ICD-10 does not impact existing CPT/HCPCS coding systems. CPT and HCPCS coding will still be in use for professional services and procedures performed in outpatient facilities.

Incident To
See section III.C.2. of this Manual.

Office for Billing Compliance (“OFBC”)
The OFBC is located at 601 West 168th Street, Suite 22, New York, NY 10032, (212) 305-3842. The OFBC also maintains a website available at http://www.cumc.columbia.edu/dept/compliance. See section I.B. of this Manual for more information.

Office of Inspector General (“OIG”)
The Office of the Inspector General of the U.S. Department of Health and Human Services is responsible for protecting the integrity of Federal health care programs, including Medicare and Medicaid.
Office of the Medicaid Inspector General ("OIG")

The Office of the Medicaid Inspector is a sub-agency within the New York Department of Health is responsible for protecting the integrity of State health care programs, including and Medicaid. The Medicaid Fraud Control Unity ("MFCU") within the Office of the New York State Attorney General has concurrent jurisdiction to investigate and prosecute instances of Medicaid fraud.

Shared Visits
An evaluation and management ("E/M") service shared or split between a physician and an NPP; shared visits are subject to specific Medicare billing rules.
APPENDIX C
FREQUENTLY ASKED QUESTIONS

1. **Does the Billing Compliance Program apply to me?**
   
The Billing Compliance Program applies to all physicians, NPPs, and staff, as well as all corporations, organizations or other entities, including external billing companies, that generate, code, submit, or are in any way involved in generating a bill for medical services. The Billing Compliance Program also addresses policies on privacy issues, identity theft, and human subject research billing compliance, which apply to all members of the CUMC community.

2. **What is my responsibility?**
   
   Professional billing must be timely, accurate, supported by appropriate medical record documentation and otherwise be in accord with applicable Federal and State regulations and CUMC policies. Patient privacy must be safeguarded, and regulations pertaining to billing for items and services furnished in connection with human subject research must be adhered to by CUMC clinicians and staff. Efforts to prevent and detect identity theft should be undertaken.

3. **Where can I find information on the Billing Compliance Plan?**
   
The OFBC maintains a website with the Compliance Plan, monitoring plan, policies and procedures. Go to [http://cumc.columbia.edu/dept/compliance](http://cumc.columbia.edu/dept/compliance).

4. **How can I contact the OFBC?**
   
The OFBC’s main number is (212) 305-3842. The website above has a directory of Billing Compliance Managers, their phone numbers and their email addresses.

5. **What is the Hotline number?**
   
The University-wide compliance hotline is (866) 627-3768.

6. **What should the Hotline be used for?**
   
   Reporting any issue or situation that raises a concern, including inconsistencies with sound billing policies and questions related to billing problems. Calls to the Hotline can be anonymous and are non-retaliatory. For issues involving privacy or HIPAA, please contact the Privacy Officer at (212) 305-7315.

7. **What do I do with audit letters and requests for refund?**
Contact your Billing Compliance Manager in the OFBC for assistance. All audit letters and refund requests should be submitted to the OFBC for tracking and assistance in completion.

8. **Where can I get a copy of my department’s compliance plan?**

   Contact your departmental compliance personnel or your departmental administrator for a copy of the department’s compliance plan.

9. **When I have coding questions where can I call?**

   All coding questions can be brought to your departmental compliance personnel for review and assistance. In addition, the OFBC maintains an "open door policy" and you may contact any one of the Billing Compliance Managers for assistance.

10. **Where do I go for compliance training?**

    Contact the OFBC or your departmental compliance personnel.
APPENDIX D
HELPFUL PHONE NUMBERS, ACRONYMS AND WEBSITES

1. Phone numbers:
   Columbia University Compliance Hotline (866) 627-3768
   CUMC Privacy Officer (212) 305-7315
   Office for Billing Compliance (212) 305-3842
   Office of the General Counsel (212) 854-0287

2. Acronyms:
   ABN - Advance Beneficiary Notice of Non-coverage
   CCS-P - Certified Coding Specialist – Physician-based
   CMS - Centers for Medicare and Medicaid Services
   CPC - Certified Professional Coder
   CPT - Current Procedural Terminology
   CUMC - Columbia University Medical Center
   DHS - Designated Health Services
   DRA - Deficit Reduction Act of 2005
   E/M - Evaluation and Management
   EMR – Electronic Medical Record
   EOB - Explanation of Benefits
   FCA - Federal False Claims Act
   FPO - Faculty Practice Organization
   GME – Graduate Medical Education
   GSA - United States General Services Administration
   HIPAA - Health Insurance Portability and Accountability Act of 1996
   ICD - International Classification of Disease
   IPA – Independent Practice Association
   LEIE - List of Excluded Individuals/Entities
   NIH - National Institutes of Health
   NPP - Non-physician Practitioner
   NYPH – New York Presbyterian Hospital
   OFBC - Office for Billing Compliance
   OIG - United States Department of Health and Human Services Office of Inspector General
   OPMC - New York State Office of Professional Misconduct
   PHI – Protected Health Information
   SPSG – Shared Practice Systems Group
   QA – Quality Assurance
   UPIN/PIN – Unique Physician Identification Number/Provider Identification Number
3. **Websites:**

   CMS - [http://www.cms.hhs.gov](http://www.cms.hhs.gov)

   Columbia University compliance website -
   [https://www.submitreport.com/columbiauniversity.jsp](https://www.submitreport.com/columbiauniversity.jsp)

   CUMC Faculty Practice Revenue Management -
   [http://www.cumc.columbia.edu/facultypractice/policies](http://www.cumc.columbia.edu/facultypractice/policies)


   OFBC - [http://www.cumc.columbia.edu/dept/compliance](http://www.cumc.columbia.edu/dept/compliance)

   OIG List of Excluded Individuals/Entities -

   OPMC List of Disciplined Individuals -
   [http://www.health.state.ny.us/nysdoh/opmc/main.htm](http://www.health.state.ny.us/nysdoh/opmc/main.htm)