

Medicare Compliance Week

News & Analysis On Fraud & Abuse, Kickbacks, Compliance Plans, & Enforcement

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OIG To Broaden Medicare SELECT Kickback Safe Harbor. In a turnabout from its longstanding position on waiving copays for non-inpatient services provided to Medicare SELECT enrollees, the **HHS Office of Inspector General** Sept. 25 offered up a proposal to expand safe harbor protections for Medicare SELECT waivers. (Page 226)

Discovery Contretemps Linger In HCA Litigation. Federal prosecutors this summer shut down their criminal investigation of individual employees of hospital chain **HCA** — and the move did a lot to loosen the discovery logjam in the epochal cost report probe of the Nashville, TN-based company. (Page 226)

OIG, CNS Zero In On Surrogate UPINs. In a Sept. 11 program memorandum (AB-02-125), the **Centers for Medicare & Medicaid Services** raised a red flag for contractors on durable medical equipment suppliers' at-times inappropriate use of surrogate physician identification numbers. But a recent report from the **HHS Office of Inspector General** suggests the problem is even bigger. (Page 226)

CMS Takes New Approach To Small Health Plans. The **Centers for Medicare & Medicaid Services** has issued more guidance on the vexing — and high-stakes — question of what it takes to qualify as a “small health plan” under the Health Insurance Portability and Accountability Act privacy regulation. (Page 227)

Golden State Takes On HIPAA Preemption Muddle. California health care providers battling with the vexing problem of when state laws supersede the Health Insurance Portability and Accountability Act privacy rule may be able to take their lead from a state agency. (Page 227)

M+C Pullouts Affect 198,000. As Congress prepares to decide whether it should funnel more money into Medicare+Choice, the program continues to shrink as plans cut their losses and ditch M+C. (Page 227)

MD Group Practice Demo To Integrate Outcomes Bonuses. The **Centers for Medicare & Medicaid Services** Sept. 27 unveiled the new physician group practice demonstration project, an initiative designed to integrate managed care-style incentives into existing fee-for-service reimbursement methods. (Page 228)

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*Kickbacks***OIG TO BROADEN MEDICARE SELECT KICKBACK SAFE HARBOR**

In a turnabout from its longstanding position on waiving copays for non-inpatient services provided to Medicare SELECT enrollees, the **HHS Office of Inspector General** Sept. 25 offered up a proposal to expand safe harbor protections for Medicare SELECT waivers.

The move is designed to bolster the languishing Medicare SELECT program, which hasn't reached its potential to some extent because kickback concerns have kept many Part B providers out of Medicare SELECT networks.

In essence, Medicare SELECT works like a preferred provider organization: Insurers can contract selectively with providers and suppliers, and enrollees pay extra to use out-of-network providers.

The OIG's safe harbor proposal, as laid out in the Sept. 25 *Federal Register*, would permit Medicare SELECT physicians and suppliers to waive Part B cost sharing amounts without running afoul of the anti-kickback statute.

Hospitals have had such safe harbor protection since 1992, with the result that Medicare SELECT coverage tends to be tilted toward Part A services.

The plan is that added protections will encourage Medicare SELECT insurers to expand their provider networks to include more doctors and suppliers.

The OIG balked at expanding the safe harbor to Part B back in 1996, citing overutilization concerns and potential False Claims Act issues.

But the watchdog agency says times have changed since then — and notes that an in-depth study published in 1997 demonstrated that the absence of a safe harbor for waivers of Part B cost sharing has been a “major impediment” to expanding Medicare SELECT.

The agency warns that “the scope of acceptable waivers under the Medicare SELECT program is within the purview of the **Centers for Medicare & Medicaid Services**,” pointing out that CMS is unlikely to authorize routine waivers for services for which payments are exclusively based on charges.

To view the proposal online, go to www.access.gpo.gov/su_docs/fedreg/frcont02.html. ❖

*Fraud & Abuse***DISCOVERY CONTRETEMPS LINGER IN HCA LITIGATION**

Federal prosecutors this summer shut down their criminal investigation of individual employees of hospital chain **HCA** — and the move did a lot to loosen the discovery logjam in the epochal cost report probe of the Nashville, TN-based company. But disagreements about who should be produced as witnesses and what kinds of documents need to be on the table still linger.

Early this year, HCA put a freeze on offering up 76 employees for depositions in some of the numerous whistleblower cases the **Department of Justice** has joined against the company. HCA maintained in part that the witnesses shouldn't have to be deposed until they knew whether they were targets of the criminal probe. With that issue off the table, at least one discovery impasse had been in some measure resolved.

But serious disagreements still fester. “Significant discovery disputes continue to dominate the landscape of this litigation,” the DOJ asserts in a Sept. 16 court filing — especially in the qui tam cases that involve cost report issues.

The DOJ notes in the filing that settlement negotiations on the cases continue. ❖

*Medicare***OIG, CMS ZERO IN ON SURROGATE UPINs**

In a Sept. 11 program memorandum (AB-02-125), the **Centers for Medicare & Medicaid Services** raised a red flag for contractors on durable medical equipment suppliers' at-times inappropriate use of surrogate physician identification numbers. But a recent report from the **HHS Office of Inspector General** suggests that the problem is bigger than anyone realized.

More than half the doctors ordering durable medical equipment have used temporary billing numbers instead of unique physician identification numbers, according to “Durable Medical Equipment Ordered with Surrogate Physician Identification Numbers” (OEI-03-01-00270). The temporary numbers should be used only when physicians lack UPINs, but 61 percent of claims with temp numbers came from docs who had UPINs of their own, says the OIG. Nearly half the surrogate UPIN claims also had missing documentation, including certificates of medical necessity. Almost 10 percent had docu-

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mentation with starting dates months after the services began.

Temp numbers raise serious concerns, the watchdog agency warns, because “the use of a surrogate UPIN on medical equipment claims allows them to be processed automatically whether the equipment has been ordered by a physician or not.”

“If the inappropriate use of surrogate UPINs by suppliers goes unchecked, the Medicare program becomes vulnerable to fraudulent billings and inappropriate payments,” the OIG adds.

CMS says it is undertaking a number of initiatives to ensure the accuracy of suppliers' UPIN reporting.

To see the report, go to <http://oig.hhs.gov/oei/reports/oei-03-01-00270.pdf>. ❖

HIPAA

CMS TAKES NEW APPROACH TO SMALL HEALTH PLANS

The **Centers for Medicare & Medicaid Services** has issued more guidance on the vexing — and high-stakes — question of what it takes to qualify as a “small health plan” under the Health Insurance Portability and Accountability Act privacy regulation.

The guidance — part of the HIPAA frequently asked questions section of CMS' Web site — appears in a revamped response to the question, “How should a health plan determine what receipts to use to decide whether it qualifies as a ‘small health plan.’” Plans that qualify as “small” get an extra year to comply with the privacy rule, making the question an extremely important one — and CMS' earlier response to the question generated controversy among HIPAA experts.

In the revised response, CMS notes that a “small health plan” is one whose annual receipts are \$5 million or less. The agency then cites guidelines promulgated by the **Small Business Administration** to clarify the complicated issue of what types of receipts should be counted toward the total.

The agency also provides new, albeit limited, HIPAA guidance: two newly added entries to the FAQ page. In the responses — posted Sept. 18 — the agency makes the following two points: First, “premiums or amounts paid for stop-loss insurance by an employer or sponsor of a self insured plan should not be included in the amount of receipts.”

Second, the Small Business Administration's recent decision to define a small business as an organization that brings in less than \$6

million in receipts per year — rather than \$5 million, as was previously the case — has no effect on the HIPAA definition of a small health plan. A small health plan remains one whose receipts are less than \$5 million. ❖

HIPAA

GOLDEN STATE TAKES ON HIPAA PREEMPTION MUDDLE

California health care providers battling with the vexing problem of when state laws supersede the Health Insurance Portability and Accountability Act privacy rule may be able to take their lead from a state agency.

Gov. **Gray Davis** (D) Sept. 11 signed a bill (S.B. 1914) assigning the authority for working out HIPAA preemption issues to the state **Office of HIPAA Implementation**. Generally, the HIPAA privacy rule trumps state laws addressing health information privacy, unless the state laws provide a higher level of protection to patients. The project of working through huge bodies of state legislation to figure out which provisions are stricter than HIPAA and which aren't, however, is a massive undertaking — and many observers have been brooding over how to get that done effectively.

The California bill gives the Office of HIPAA Implementation “the authority to determine which provisions of state law concerning personal medical information are preempted by HIPAA” and charges it with assuming “statewide leadership, coordination, direction, and oversight responsibilities” for the HIPAA preemption analysis. ❖

Medicare+Choice

M+C PULLOUTS AFFECT 198,000

As Congress prepares to decide whether it should funnel more money into Medicare+Choice, the program continues to shrink as plans cut their losses and ditch M+C.

Responding to the unprofitability of Medicare+Choice on the county and partial-county level, managed care organizations on Sept. 9 began yet another round of exits from the program for 2003. The **Centers for Medicare & Medicaid Services** Sept. 25 said more than 198,000 enrollees will be affected.

That figure is significantly lower than many expected and less than half of the 536,000 who lost plans in 2002. Nevertheless, “a program with 200,000 people being affected [by withdrawals] is

not a stable program,” according to **American Association of Health Plans** President **Karen Ignani**. This round of exits appears to be more than a mad retreat, as plans are expertly choosing the markets that are profitable enough to stick with.

Once insurers withdraw from M+C, it is hard for them to re-enter because of the expense of reassembling networks and contracts and the difficulty of overcoming beneficiary distrust, CMS Administrator **Tom Scully** warned Sept. 10. That makes acting quickly to shore up the program important, and Scully said the administration will bolster M+C administratively if Congress fails to act this year. ❖

Medicare

MD GROUP PRACTICE DEMO TO INTEGRATE OUTCOMES BONUSES

The **Centers for Medicare & Medicaid Services** Sept. 27 unveiled the new physician group practice demonstration project, an initiative designed to integrate managed care-style incentives into existing fee-for-service reimbursement methods.

In a notice published in the *Federal Register*, CMS said it would use a competitive process to select up to six group practices to participate in the three-year PGP demo.

The demo “will provide a unique reimbursement mechanism through which providers are rewarded for coordinating and managing the overall health care needs of a nonenrolled, fee-for-service patient population,” CMS says. “It offers an opportunity to test whether a different financial incentive structure can improve service delivery and quality for Medicare patients, and ultimately prove cost effective.”

Under the demo, annual performance targets will be established for each participating group practice. Practices will continue to be paid under existing Medicare fee schedules — but they also will be able to earn a bonus from any savings achieved against their performance target.

The PGP demo, which includes explicit incentives for process and outcome improvement, “superimposes new incentives on traditional fee-for-services reimbursement that are more in line with those used by managed care organizations and other commercial payers,” CMS explains.

To see the notice announcing the demo, go to www.access.gpo.gov/su_docs/fedreg/a020927c.html. ❖

Medicaid

SHOW-ME STATE, OIG CLASH OVER DSH PAYMENTS

The state of Missouri and the **HHS Office of Inspector General** are at odds over what sorts of costs can be included in disproportionate share hospital calculations under the state’s Medicaid plan.

In “Review of Disproportionate Share Hospital Costs Claimed by the State of Missouri for Fiscal Year Ended June 30, 1999” (A-07-01-02093), the OIG maintained that by including non-hospital costs — community mental health center costs in particular — in its DSH calculations, Missouri collected more than \$36 million worth of federal funds that it wasn’t entitled to.

The **Missouri Health Department** disagreed, arguing that its CMHCs in fact provide outpatient hospital services within the meaning of its Medicaid plan, and that the costs for those services should be accounted for in DSH calculations.

The OIG stuck to its guns, however, and recommended that the state repay \$36.2 million to the federal government and change its policies for making DSH claims.

To see the report, go to <http://oig.hhs.gov/oas/reports/region5/50200028.pdf>. ❖

Enforcement

11 INDICTED IN MOTOR CITY FRAUD ROUNDUP

A lengthy probe of a Detroit medical clinic, home health agency and durable medical equipment supplier has culminated in the indictment of 11 of the clinic’s employees, U.S. Attorney **Jeffrey Collins** reports.

The investigation centered on **Midwest Family Clinic** (which does business as **Mobile Doctors, Midwest Home Health Care Inc.**) and **Midwest Health Services** (also known as **Superior Medical Equipment**), both of which are located at a single address in Detroit. The indictment — returned on July 10 and unsealed Sept. 10 — outlines a number of abusive billing practices, including:

- soliciting Medicare beneficiaries to get free care from Mobile Doctors, billing Medicare, but never attempting to collect co-payments;
- billing for unnecessary tests and for services not rendered;
- referring patients for home health and DME to businesses that had common ownership with Mobile Doctors, in violation of federal regulations;

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- falsifying dates of services for diagnostic tests to increase reimbursement; and
- fraudulently certifying the need for home health care and DME.

Named in the indictment are: **Samuel Ajiri, Zeyn Seabron, Michael Branch, Eddie Bartolomei, Jose Castro Ramirez, Napoleon Imperio, Emerenciano Sarabia, Roy Elrod, Rafael Roman, Craig Strobel and Libertad Montanez.** ❖

Long-Term Care

WHITHER GOEST CMPs?

Ever wonder what states do with the civil monetary penalties they collect from long-term care facilities for survey deficiencies?

The **Centers for Medicare & Medicaid Services** recently instructed states to use such funds for any project that directly benefits facility residents, including funding ombudsman services.

States should not finance loans to deficient facilities that are having financial difficulties in meeting payroll or paying vendors, CMS' Survey and Certification Group warns in recent correspondence (S&C-02-042).

However, states could prevent facilities' continued noncompliance by developing videos, pamphlets, or other publications to promote best practices, including the development of public service announcements related to "deficient areas" and employing consultants to provide training to deficient facilities.

CMS notes, for example, that North Carolina and other states have issued grants to several nursing facilities to fund Eden Alternative projects, which provide training and other services to support therapeutic use of animals. ❖

Enforcement

PERSISTENCE DOESN'T PAY

A Virginia doctor will spend more than 3 years in prison for engaging in a scheme to defraud, initially, the **Department of Labor's** Black Lung Program, and then, when the DOL caught on to him, Medicare, Medicaid and other payors.

According to U.S. Attorney **John Brownlee**, Dr. **Vinodchandra "Vinod" Modi** was sentenced Sept. 20 to 37 months in prison after pleading guilty to conspiracy to commit money laundering, mail fraud, and unlawful distribution of a controlled substance. He also was ordered to

pay a \$75,000 fine and permanently surrender his license to practice medicine in the U.S.

Vinod Modi and his wife **Kailas Modi**, both physicians, operated Miners Medical Clinic in Oakwood, VA. Prosecutors say Vinod Modi billed the Black Lung Program under his wife's name and physician number during periods when either his medical license or his Black Lung Program billing privileges were suspended. When the DOL caught on, it suspended Kailas Modi's billing privileges as well — at which point, prosecutors say, the pair continued to see their Black Lung patients, but documented the cases in such a way as to be able to submit claims for payments from Medicare. The pair also unlawfully prescribed Fiorinal #3, a schedule III controlled substance.

Kailas Modi pleaded guilty to the drug charge, and was sentenced to five years probation with six months of home confinement. She agreed to surrender her medical license for five years. The Modis also must pay \$2 million in restitution, on top of nearly \$1.5 million the pair has forfeited to the U.S. government. ❖

Regulation

CMS POSTS QUARTERLY REGULATORY ROUNDUP

Missed any marching orders from the **Centers for Medicare & Medicaid Services**?

Here's a quick test to find out: CMS published in the Sept. 27 *Federal Register* a compendium of Medicare and Medicaid program issuances released between April and June 2002. The quarterly update includes CMS manual instructions, substantive and interpretive regulations, and other *Federal Register* notices, along with program memoranda and national coverage determinations.

To view the update, go to www.access.gpo.gov/su_docs/fedreg/a020927c.html. ❖

Reimbursement

PROGRAM MEMO ROUNDUP

The **Centers for Medicare & Medicaid Services** Sept. 27 issued a trio of program memoranda designed to clarify issues relating to the newly minted ambulance fee schedule.

Program memo B-02-060 (http://cms.hhs.gov/manuals/pm_trans/B02060.pdf) outlines claims processing instructions for situations when multiple patients are transported simultaneously in the same ambulance.

Definitions of ambulance services, as outlined in the Feb. 27, 2002 ambulance fee schedule final rule, are clarified in memo AB-02-130 (http://cms.hhs.gov/manuals/pm_trans/AB02130.pdf).

The third transmittal, program memo AB-02-131 (http://cms.hhs.gov/manuals/pm_trans/AB02131.pdf), clarifies CMS policy on the following issues: implementation of the fee schedule, sources of additional information, no transport, healthcare common procedure coding system codes, zip codes, basic life support/advanced life support joint responses, ground-to-air ambulance transports, mileage and payment for supplies and ancillary services.

In other recent program memoranda, CMS:

- lays out claims processing requirements for clinical diagnostic laboratory services based on negotiated rulemaking (AB-02-129; http://cms.hhs.gov/manuals/pm_trans/AB02129.pdf);

- issues temporary procedures for cost-based payments for certified registered nurse anesthetist services furnished by outpatient prospective payment system hospitals (A-02-089; http://cms.hhs.gov/manuals/pm_trans/A02089.pdf);

- summarizes coverage and billing issues for percutaneous image-guided breast biopsies (AB-02-128; http://cms.hhs.gov/manuals/pm_trans/AB02128.pdf);

- outlines its schedule for completing 2003 fee schedule updates and participating physician enrollment procedures (B-02-061; http://cms.hhs.gov/manuals/pm_trans/B02061.pdf);

- advises fiscal intermediaries and carriers that the 2003 HCPCS annual update will be available to them on Oct. 9, 2002 (AB-02-132; http://cms.hhs.gov/manuals/pm_trans/AB02132.pdf);

- orders contractors to publish and maintain a directory of electronic billing vendors (AB-02-133; http://cms.hhs.gov/manuals/pm_trans/AB02133.pdf);

- modifies the health care eligibility benefit response and direct data entry screens for home health agencies and hospice providers (A-02-091; http://cms.hhs.gov/manuals/pm_trans/A02091.pdf);

- instructs carriers (except the durable medical equipment regional carriers) to activate the automated unsolicited response for skilled nursing facility consolidated billing (B-02-059; http://cms.hhs.gov/manuals/pm_trans/B02059.pdf);

- advises FIs that version 28.0 of the provider statistical and reimbursement report will be available on Nov. 15, 2002 (A-02-088; http://cms.hhs.gov/manuals/pm_trans/A02088.pdf);

- issues file descriptions and instructions to FIs for retrieving the 2003 physician, clinical lab, DME, and therapy fee schedule payment amounts from the CMS mainframe (A-02-090; http://cms.hhs.gov/manuals/pm_trans/A02090.pdf);

- orders FIs and carriers to establish a uniform process for transmitting case files from their appeals unit to the Social Security Administration's Office of Hearings and Appeals (AB-02-126; http://cms.hhs.gov/manuals/pm_trans/AB02126.pdf). ❖

Clarification: A piece titled "OIG Plans Town Hall Meetings" in MCW, vol. 3, no. 37 contained information on attending an OIG-sponsored regional town hall meeting in Boston.

Please note that this meeting is intended for members of the provider community in Region I — it is not a national meeting. We regret any confusion this may have caused.

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HIPAA Privacy for EMPLOYEES

Your first line of defense against privacy woes is an educated work force.

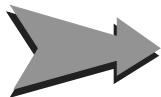
In today's privacy-conscious world, everyone at your health care work place must be able to answer these questions – and more.

- **Can I still fax and email patient records?**
- **What is — and is not — protected health information under HIPAA?**
- **What do I do if confidential information gets leaked?**
- **How will HIPAA change the way I do my job?**

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- Even minor HIPAA lapses can leave you facing accreditation woes, exploding fines and possible jail time.

- Time is running out — everyone at your facility *must* be on board before April 2003.



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- We've stripped away the legalese and mumbo jumbo to bring your employees the simplest, most reliable training possible.
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- ◆ What is private information?
- ◆ How does this apply to me?
- ◆ Conversations: how to talk, how to listen
- ◆ When does HIPAA start?
- ◆ Who do we do business with?
- ◆ Can I get in trouble?
- ◆ Case scenarios: What will HIPAA look like at my organization?



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Edited by Kristen Rosati, Esq., one of the most recognized and trusted HIPAA educators, Eli's privacy handbook takes the doubt out of your HIPAA privacy training.

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Sample Page

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What is Protected Health Information, or PHI?

In a nutshell, PHI is any health information created or received by your employer that identifies a specific person. The main categories of PHI are electronic records, paper records and spoken communication.

A patient's medical record is one of the most visible pieces of PHI. But PHI can include other materials and information that you may not have thought about before. Things like a patient status boards, insurance cards, codes that document a certain procedure, physician dictation tapes — even calling out a patient's name in the waiting room can count as PHI!

Every privacy
concept in
here is up to
the minute!

Some kinds of information become PHI only in combination with other pieces of information. A ZIP code alone won't identify a person, but along with other identifiers — like an insurance card and a telephone number — the ZIP code could be an important clue to the person's identity. Therefore, the ZIP code is PHI because it gives you a reasonable basis for connecting information to a person's identity.

Along these lines, any information that reveals the past, current or likely future state of a person's health counts as PHI.

ALL health information that identifies an individual is protected under HIPAA. It doesn't matter whether your organization creates the health information or receives it from another source, like a lab or an ambulance service. You must treat it just as carefully as information generated by your facility.

Individual Identifiers can include:

- Names
- ZIP codes
- Dates of birth
- Telephone numbers
- FAX numbers
- E-mail addresses
- Social Security numbers
- Medical Record numbers
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