“Coding Compliance . . . Having An Effective Program/Plan”

HCCA
January 2018
Webinar

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Speaker

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Disclaimer

- This material is designed and provided to communicate information about compliance, ethics and coding in an educational format and manner.
- The author is not providing or offering legal advice, but rather practical and useful information and tools to achieve compliant results in the area of compliance, ethics, clinical documentation, data quality, and coding.
- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.

Goals/Objectives

- ***Review*** Key Compliance Program Elements
- ***Provide*** information on Compliance "Effectiveness"
- ***Discuss*** the major components of a "Coding Compliance" Program/Plan
- ***Enhance*** knowledge and understanding of ethical standards and the linkage to compliance.

Background: False Claims Act (FCA)

- "A false claim can take many forms, the most common being a claim for goods or service not provided or provided in violation of contract terns, specification, statute or regulation."

- S.Rep.No.99-345 at 9 reprinted in 1986 U.S.C.C.A.N. 5266,5274

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Background: False Claim Act (FCA)

- HIM Coding Professionals should have knowledge of the False Claims Act (FCA).
- Note that liable to the US Government was between $5000 and not more than 11,000 plus treble damages per violation…….. A change occurred after November 2nd, 2015 and the range is now $10,781 to $21,562.
- Example: A physician knowingly submits claims to Medicare for a higher level of medical services than actually provided or higher than the medical record documents.
  - Penalties: Civil penalties for violating the FCA may include fines of up to three times the amount of damages sustained by the Government as a result of the false claims plus up to $21,563 (in 2016) per false claim filed.

Background: Office Inspector General

- Health Care Fraud and Abuse Control Program (HCFAC or the Program) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS)1, acting through the Inspector General, designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse.
- **During Fiscal Year (FY) 2016**, the Federal Government won or negotiated over $2.5 billion in health care fraud judgments and settlements2, and it attained additional administrative impositions in health care fraud cases and proceedings.
- **In FY 2016 over $3.3 billion** was returned to the Federal Government or paid to private persons.

Source: The Department of Health and Human Services And The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2016 – January 217

Background: Office Inspector General (cont.)

- During the first half of **FY 2017**, the Office of Inspector General (OIG) reported expected investigative recoveries of over **$2.04 billion**.
- The OIG also reported 468 criminal actions against individuals or entities that engaged in crimes against HHS programs, 461 civil actions, and 1,422 exclusions of individuals and entities from participation in federal health care programs.

Background: Key Message from OIG

- "It's Incumbent upon a health system's corporate officers and managers to provide ethical leadership to the organization and to assure that adequate systems are in place to facilitate ethical and legal conduct."

- Office of Inspector General

Now note: it says "ethical" and "Legal", keep in mind that unethical behavior or acts are not always illegal.

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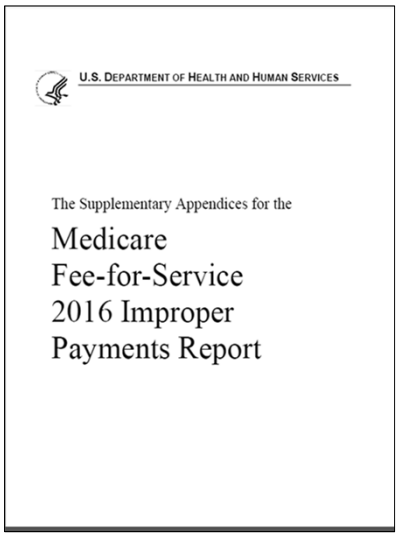
HHS Report: Medicare FFS Improper Payments



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Supplementary Appendices for the

Medicare
Fee-for-Service
2016 Improper
Payments Report

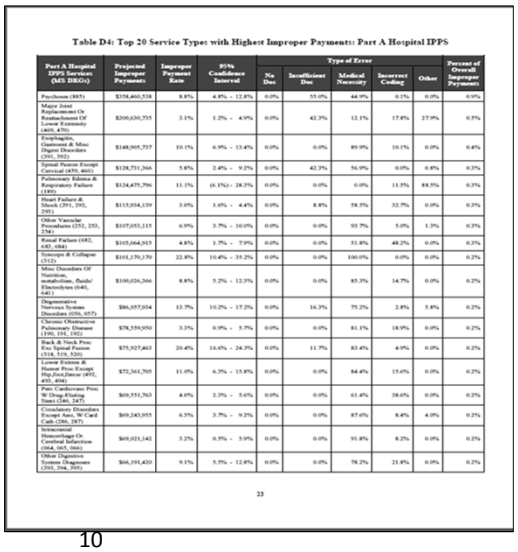


Table D4: Top 20 Service Types with Highest Improper Payments: Part A Hospital IPPS

Part A Hospital IPPS Services (MS DRGs)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Psychoses (885)	$378,460,538	8.8%	4.8% - 12.8%	0.0%	55.0%	44.9%	0.1%	0.0%	0.9%
Major Joint Replacement Or Reattachment Of Lower Extremity (469, 470)	$200,630,735	3.1%	1.2% - 4.9%	0.0%	42.3%	12.1%	17.8%	27.9%	0.5%
Esophagitis, Gastroent & Misc Digest Disorders (391, 392)	$148,905,737	10.1%	6.9% - 13.4%	0.0%	0.0%	89.9%	10.1%	0.0%	0.4%
Spinal Fusion Except Cervical (459, 460)	$128,731,366	5.8%	2.4% - 9.2%	0.0%	42.3%	56.9%	0.0%	0.8%	0.3%
Pulmonary Edema & Respiratory Failure (189)	$124,475,796	11.1%	(0.1%) - 28.3%	0.0%	0.0%	0.0%	11.5%	88.5%	0.3%
Heart Failure & Shock (291, 292, 293)	$115,934,139	3.0%	1.6% - 4.4%	0.0%	8.8%	58.5%	32.7%	0.0%	0.3%
Other Vascular Procedures (252, 253, 254)	$107,053,115	6.9%	3.7% - 10.0%	0.0%	0.0%	93.7%	5.0%	1.3%	0.3%
Renal Failure (682, 683, 684)	$105,064,915	4.8%	1.7% - 7.9%	0.0%	0.0%	51.8%	48.2%	0.0%	0.3%
Syncope & Collapse (312)	$101,170,170	22.8%	10.4% - 35.2%	0.0%	0.0%	100.0%	0.0%	0.0%	0.2%
Misc Disorders Of Nutrition, metabolism, fluids/ Electrolytes (640, 641)	$100,026,266	8.8%	5.2% - 12.3%	0.0%	0.0%	85.3%	14.7%	0.0%	0.2%
Degenerative Nervous System Disorders (056, 057)	$86,057,934	13.7%	10.2% - 17.2%	0.0%	16.3%	75.2%	2.8%	5.8%	0.2%
Chronic Obstructive Pulmonary Disease (190, 191, 192)	$78,559,950	3.3%	0.9% - 5.7%	0.0%	0.0%	81.1%	18.9%	0.0%	0.2%
Back & Neck Proc Except Spinal Fusion (518, 519, 520)	$75,927,463	20.4%	16.6% - 24.3%	0.0%	11.7%	83.4%	4.9%	0.0%	0.2%
Lower Extrem & Humer Proc Except Hip,foot,femur (492, 493, 494)	$72,361,705	11.0%	6.3% - 15.8%	0.0%	0.0%	84.4%	15.6%	0.0%	0.2%
Perc Cardiovasc Proc W Drug-Eluting Stent (246, 247)	$69,551,763	4.0%	2.3% - 5.6%	0.0%	0.0%	61.4%	38.6%	0.0%	0.2%
Circulatory Disorders Except Ami, W Card Cath (286, 287)	$69,243,955	6.5%	3.7% - 9.2%	0.0%	0.0%	87.6%	8.4%	4.0%	0.2%
Intracranial Hemorrhage Or Cerebral Infarction (064, 065, 066)	$69,021,142	3.2%	0.5% - 5.9%	0.0%	0.0%	91.8%	8.2%	0.0%	0.2%
Other Digestive System Diagnoses (393, 394, 395)	$66,191,420	9.1%	5.5% - 12.8%	0.0%	0.0%	78.2%	21.8%	0.0%	0.2%

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Medicare Compliance Report (OIG)

- **Evaluation and Management: Correct Coding — Reminder**
- In a study report, the Office of the Inspector General (OIG) noted that 42 percent of claims for Evaluation and Management (E/M) services in 2010 were incorrectly coded, which included both upcoding and downcoding (i.e., billing at levels higher and lower than warranted), and 19 percent were lacking documentation.
- A number of physicians increased their billing of higher level, more complex and expensive E/M codes
- Many providers submitted claims coded at a higher or lower level than the medical record documentation supports
- Use the following resources to bill correctly for E/M services:
  - Improper Payments For Evaluation and Management Services OIG Report
  - Claims Processing Manual: Chapter 12, Section 30.6
  - E/M Services Guide
  - 1995 Documentation Guidelines for E/M Services
  - 1997 Documentation Guidelines for E/M Services
  - Frequently Asked Question on Use of 1995 and 1997 Guidelines
  - Provider Compliance Tips for E/M Services Fact Sheet
  - E/M Services Web-Based Training course available through the Learning Management System

Healthcare Top Risk Areas

- **Clinical Excellence (Quality Patient Care)**
- **Accountable Care Organizations**
- **The 340B Drug Discount Program**
- **Physician Contracting**
- **Physician Compensation**
- **HIPAA**
- **Cybersecurity**
- **System Implementation**
- **System Access Management**
- **IT General Controls**
- **Third-Party Vendor Management**
- **Care (Case) Management**
- **Clinical Documentation Improvement**
- **Medication Management and Drug Diversion**
- **Nonphysician Contract Management**
- **Billing and Collections**
- **Patient Access**
- **Inpatient Coding**
- **Charge Capture**
- **Physician Practice Coding and Billing**

Source: 4/2017 Crowe Horwath.com

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Healthcare Compliance News . . .

- **In July 2017**, Utah pain doctor Jahan Imani, MD, and Intermountain Medical Management, P.C., entered into a nearly $400,000 settlement with the OIG to resolve allegations that Imani's practice submitted false or fraudulent claims due to improper modifier use for payment by improperly using modifier -59 with HCPCS code G0431.
- **OIG October 2017**: Intensity-Modulated Radiation Therapy. Intensity-modulated radiation therapy (IMRT) is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. Prior OIG reviews identified hospitals that incorrectly billed for IMRT services. We will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements.

Healthcare Compliance News . . .

- **OIG November 2017 requests $10.2 million in overpayment refunds from medical center (Rush University Med Ctr. in Chicago) .** Out of the 120 claims reviewed by the OIG, 51 inpatient claims and six outpatient claims reportedly have billing errors. The majority of the overpayments were due to inpatient claims. Part of this amount is from a review of inpatient claims billed with high-severity-level DRG codes that "did not fully comply with Medicare billing requirements."
- **OIG November 2017:** Medicare Claims on Which Hospitals Billed for Severe Malnutrition. Many elderly Medicare patients, especially those who are severely ill, are malnourished. Malnutrition can result from such things as the treatment of another condition, inadequate treatment or neglect, or the general deterioration of a patient's health. Hospitals are allowed to bill for the treatment of malnutrition on the basis of the severity of the condition -- mild, moderate or severe, and whether it affects patient care. This review would assess the accuracy of Medicare payments for the treatment of severe malnutrition. **Severe malnutrition is classified as a major complication or comorbidity (MCC). Adding an MCC to a Medicare claim can result in a higher Medicare payment because the claim is coded at a higher Diagnosis Related Group.**

OIG Compliance Program Guidance

Seven Elements of a Compliance Program:

1. Standards of Conduct
2. Compliance Officer and Board/Committee
3. Education
4. Auditing and Monitoring
5. Reporting and Investigations
6. Enforcement and Discipline
7. Response and Prevention

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What a Compliance Program should do . . .

- Provide oversight to **Detect, Prevent and Correct** "Fraud, Waste and Abuse".
- Define expectations
- Create and foster a culture of compliance
  - Do the right thing
- Encourage reporting
  - Open lines of communication
- Monitoring and Auditing
- Education

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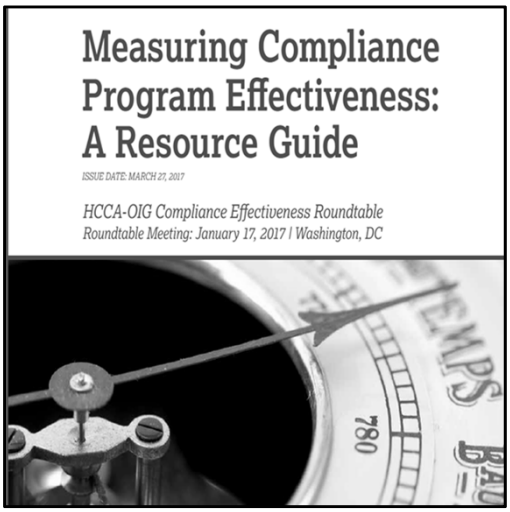
BUT IS YOUR COMPLIANCE PROGRAM EFFECTIVE?

- During 2017 you should have asked this question and maybe even more than once.
- Checks and Balances: open and transparent.
- ALL Settings!
  - SNF, Rehab, Long Term Care and Hospice, etc.
- 2018 is the year to be effective!

OIG & HCCA Released Guidance March 2017



Question: How do YOU or WE know our compliance plan/program and those efforts are effective?

Resource Guide Content

1. Standards, Policies and Procedures
2. Compliance Program Administration
3. Screening and Evaluation of Employees, Physicians, Vendors and Other Agents
4. Communication, Education, and Training on Compliance Issues
5. Monitoring, Auditing and Internal Reporting Systems
6. Discipline for Non-Compliance
7. Investigations and Remedial Measures

NOTE: The correlation with the OIG Seven Key Elements!

We'll take a look at the first element today.

Element 1: Standards, Policies, and Procedures		
	What to Measure	How to Measure
	Access:	
1.1	Accessibility	• Review link to employee accessible website/intranet that includes the Code of Conduct • Survey - Can you readily access or reference policies and procedures? (Yes/No/Don't know) • Survey - How and where do employees actually access policies and procedures? • Test key word search (searchable) • Audit and interview staff to show policies
1.2	Actual Access	Audit how many actual "hits" on policies and procedures
1.3	Accessible language for code, standards and policies	Flesch Kincaid measuring standard – no more than 10th grade reading level
1.4	Compliance program awareness and communication	• Survey employees to determine the extent to which the code of conduct and other compliance communications are available to employees • Review to ensure the standards, policies, and awareness material is updated and distributed within organization's guidelines
1.5	Impaired or disabled accessibility	Review accessibility options. Look at methods and speak to individuals.
1.6	Policy communication	Communication strategy of policies
1.7	Availability of policy content	Conduct surveys and observation
	Accountability:	
1.8	Accountability	Policy Coordinator designated
1.9	Ownership and accountability of policies	Audit process of how policies get enforced by chain of command when compliance is not the final approver. Is management taking responsibility for implementing and following policies?
1.10	Routine policies and procedures	Confirm that listed owner of each policy and procedure is the actual owner.

	Review/Approval Process:	
1.11	Annual review and Board approval of Compliance Plan	Audit: Review of Board minutes
1.12	Compliance documentation operations manual	Compliance or other oversight committee to review annually to ensure it is up to date.
1.13	Maintenance of policies	Check last review or revision
1.14	Number of policies reviewed and is the review timely	Process review/audit. Use checklist to ensure all basic policy elements are in place, updated consistently and reviewed/approved by appropriate parties.
1.15	Policy approvals	Checklist audit. Create list of policies, review committee and board minutes to ensure all approvals have been obtained.
1.16	Policy review process	Audit process by which policies and procedures are prepared, approved, disseminated, etc.
1.17	Process for ensuring full organizational participation in policy and procedure development	Review documentation/minutes to verify input considered and solicited for policy and procedure development and review
1.18	Process for review and approving	Check for written process
	Quality:	
1.19	Are policies (and procedures) as good as industry practice	Peer reviews
1.20	Integrity of Process for developing and implementing policies and procedures	Audit policy and procedure on policy and procedures
1.21	Language and reading level of policies	Are policies written in plain language, appropriate grade reading level and written in applicable languages for organization? Policy review, Word grade level review and interviews of staff to make sure they understand.
1.22	Language translation	Audit or process review. Are policies and the code of conduct translated into appropriate languages for organization?
1.23	Usefulness	SURVEY - Do department policies and procedures assist you in doing your job effectively? (Yes/No/Don't know)

1.24	Need for policies that don't exist	Interview staff to determine if they need the certain policies to strengthen internal controls.
1.25	Policies and procedures	Request review from external experts
	Assessment:	
1.26	Assessment of all company policies	Check list of policies; which are compliance and which are business
1.27	Essential compliance policies and procedures exist	Can staff actually articulate policies and procedures; test staff
1.28	Existence of procedure to support policy	Audit for procedure to support policy
1.29	Fundamental policies and procedures in place	Have focus groups of work units/departments to determine whether they understand the policies and procedures necessary to do their jobs.
1.30	Identifiability	• Index of policies available and current • Numbered policies, not just titles
1.31	List of policies are applicable to employees	Supervisors to assess direct staff
1.32	Are those affected by policy given the opportunity to weigh in on policy when developed?	Focus groups and interviews of those affected by policy.
1.33	List of required policies	Create checklist to make sure minimum policies are in place and then audit against the list.
1.34	Effectiveness of policies	Effectiveness of policies based on the submission hotline calls
1.35	Policies and procedures that have been identified as part of corrective action	Process review. Conduct annual meeting with compliance and legal to look at databases and control and prioritize review to ensure implementation and ongoing compliance with policies and procedures.
1.36	Policies for high risk and operational areas	Audit
1.37	Policies, standards and procedures are based on assessed risks	Risk assessment, policy exists for each risk identified in the risk assessment (coverage of a specific risk topic)
1.38	Policy inventory to ensure no overlap and contradiction of policies	Create inventory and analyze inventory. Analyze and review past efforts. Look at various departments that might have overlapping policies.
1.39	Policy review following investigation/issue	Top policies implicated in an investigation are reviewed to determine if policy ambiguous, complex, fails to adequately safeguard issues. Validate through audit.

1.40	Routine policies and procedures are addressed and filter down.	Review department and committee agendas to ensure policies are addressed
	Code of Conduct:	
1.41	Code of Conduct	Audit: Review dates, board approvals, distribution processes, attestations, survey employees for understanding, conduct focus groups.
1.42	Compliance program awareness and communication	Survey employees to determine the extent to which they know the content of the Standards of Conduct (SOC) and how to access it.
1.43	Integrate mission, vision, values, and ethical principles with code of conduct	Compare code with mission and vision statements to see if it includes elements/statements. Check to see if code is accessible to employees
1.44	Maintenance of code of conduct	Is code written, posted for employees, documented frequency of reviews, and survey/test employees on ability to locate it
1.45	Distribution	Documentation of Code of Conduct distribution tracking and results over past two years for all employees, employed physicians, allied health professionals, independent (contracted) physicians, volunteers and vendors/contractor/consultants in the organization
1.46	Orientation	Audit to ensure all employees receive orientation to the SOC and compliance policies within 30 days of hire.
1.47	Staff understanding of code of conduct and policies and procedures	• Review test scores after training. • Conduct interviews.
	Updates:	
1.48	Compliance program communication of rule changes	Review periodically and at rule changes – Audit to ensure there is adequate communication to employees, including changes in policy/procedure.
1.49	New and updated policy distribution and education of appropriate staff	Process review - Does organization have formal process to make workforce aware of new policies or changes in policies?
1.50	Practices implemented after new policy	Audit practices and review committee minutes and other documentation to determine how new policies are implemented.
	Understanding:	
1.51	Understanding of Policies/Procedures	• Conduct surveys and/or focus groups on specific policies

		• Audit adherence to policy/procedure
1.52	Orientation	Ensure employees are provided instruction by knowledgeable personnel for questions/clarity
1.53	Policies reflect practice	Use policies as audit tool and then interview, observe and conduct document review to ensure policies are being followed.
1.54	Questions asked by employees	System in place to track employee questions and concerns to ensure consistent guidance. Track departments where questions come from to deploy additional education where necessary.
1.55	Understandable to board and c-suite	Test board and c-suite on location and understanding
1.56	Understandable to employees	• Reading comprehension test • Situational tests • Test of location
	Compliance Plan:	
1.57	Maintain compliance plan and program	Review written plan or written schedule of compliance activities
1.58	Maintain compliance department operations manual	• Audit existence of written manual, handbook, or reference guide • Test whether the manual is current
	Confidentiality Statements:	
1.59	Verify maintenance of appropriate confidentiality policies	• Audit procedure for obtaining confidentiality statements from employees • Audit employee files for signed confidentiality statements from employees
	Enforcement:	
1.60	Compliance with policies	Conduct interviews, observation.
1.61	Policy violations	Audit policy and procedures to make sure practice consistent with policy.
1.62	Adherence to policies and procedures for cases involving patient harm and reporting to regulatory agency	Review policies and procedures and cases involving patient harm and validate proper reporting to regulatory agency

Being Ethical

- A key component to **workplace ethics** and behavior is integrity, or **being** honest and doing the right thing at all times.
  - For example, health care employees who work with mentally or physically challenged patients must possess a high degree of integrity, same as those who manage and work primarily with money.
- **Ethical behavior** tends to be good for business and involves demonstrating respect for key moral principles that include honesty, fairness, equality, dignity, diversity and individual rights.

"An ethical culture is created by the organization's leaders who manifest their ethics in their attitudes and behavior." McMillan, Michael. "Codes of Ethics: If You Adopt One, Will They Behave?".

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Standards of Conduct

- Standards of Conduct or "code of conduct" are the rules set up that outline social norms, religious rules and responsibilities of proper practices and action, where for an individual, organization, or party.
  - *"Principles, values, standards, or rules of behavior that guide the decisions, procedures and systems of an organization in a way that (a) contributes to the welfare of its key stakeholders, and (b) respects the rights of all constituents affected by its operations."*

Source: 2007 International Good Practice Guidance, "Defining and Developing an Effective Code of Conduct for Organizations", the International Federation of Accountants

Coding Professional

- Health Information Management (HIM), health records or medical records oversight via credential individual(s)
- Clinical Coding is a core function of HIM; also needs to have credentialed individual(s).
- These coding practitioners:
  - Review patients' records and assign numeric codes for each diagnosis and procedure
  - Possess expertise in the ICD-10-CM and CPT coding systems
  - Are knowledgeable about medical terminology, disease processes, and pharmacology.
  - Documentation, Reimbursement systems, and revenue cycle
- Applies to all healthcare settings!
- Ethical, professional and compliant!

REMEMBER: Clinical Coding is used to translate medical documentation (the language of medicine) into medical data (the language of coding) for statistical, research, and reimbursement purposes.

AHIMA Code of Ethics

- **Purpose of the American Health Information Management Association Code of Ethics**
- The HIM professional has an obligation to demonstrate actions that reflect values, ethical principles, and ethical guidelines. The American Health Information Management Association (AHIMA) Code of Ethics sets forth these values and principles to guide conduct. (See also AHIMA Vision, Mission, Values)
- The code is relevant to all AHIMA members and CCHIIM credentialed HIM professionals [hereafter referred to as certificants], regardless of their professional functions, the settings in which they work, or the populations they serve. These purposes strengthen the HIM professional's efforts to improve overall quality of healthcare.

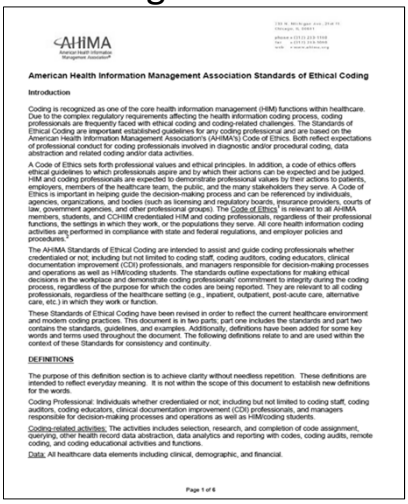
AHIMA Code of Ethics (cont.)

The AHIMA Code of Ethics serves seven purposes:

- 1. Promotes high standards of HIM practice.
- 2. Identifies core values on which the HIM mission is based.
- 3. Summarizes broad ethical principles that reflect the profession's core values.
- 4. Establishes a set of ethical principles to be used to guide decision-making and actions.
- 5. Establishes a framework for professional behavior and responsibilities when professional obligations conflict or ethical uncertainties arise.
- 6. Provides ethical principles by which the general public can hold the HIM professional accountable.
- 7. Mentors practitioners new to the field to HIM's mission, values, and ethical principles.

AHIMA Standards of Ethical Coding

- 12/2016 AHIMA Updated Standards of Ethical Coding



AHIMA

American Health Information Management Association Standards of Ethical Coding

Introduction

Coding is recognized as one of the core health information management (HIM) functions within healthcare. Due to the complex regulatory requirements affecting the health information coding process, coding professionals are frequently faced with ethical coding and coding-related challenges. The Standards of Ethical Coding are important established guidelines for any coding professional and are based on the American Health Information Management Association's (AHIMA's) Code of Ethics. Both reflect expectations of professional conduct for coding professionals involved in diagnostic and/or procedural coding, data abstraction and related coding and/or data activities.

A Code of Ethics sets forth professional values and ethical principles. In addition, a code of ethics offers ethical guidelines to which professionals aspire and by which their actions can be expected and be judged. HIM and coding professionals are expected to demonstrate professional values by their actions to patients, employers, members of the healthcare team, the public, and the many stakeholders they serve. A Code of Ethics is important in helping guide the decision-making process and can be referenced by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, insurance providers, courts of law, government agencies, and other professional groups). The Code of Ethics[1] is relevant to all AHIMA members, students, and CCHIIM credentialed HIM and coding professionals, regardless of their professional functions, the settings in which they work, or the populations they serve. All core health information coding activities are performed in compliance with state and federal regulations, and employer policies and procedures.[2]

The AHIMA Standards of Ethical Coding are intended to assist and guide coding professionals whether credentialed or not, including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students. The standards outline expectations for making ethical decisions in the workplace and demonstrate coding professionals' commitment to integrity during the coding process, regardless of the purpose for which the codes are being reported. They are relevant to all coding professionals, regardless of the healthcare setting (e.g., inpatient, outpatient, post-acute care, alternative care, etc.) in which they work or function.

These Standards of Ethical Coding have been revised in order to reflect the current healthcare environment and modern coding practices. This document is in two parts; part one includes the standards and part two contains the standards, guidelines, and examples. Additionally, definitions have been added for some key words and terms used throughout the document. The following definitions relate to and are used within the context of these Standards for consistency and continuity.

DEFINITIONS

The purpose of this definition section is to achieve clarity without needless repetition. These definitions are intended to reflect everyday meaning. It is not within the scope of this document to establish new definitions for the words.

Coding Professional: Individuals whether credentialed or not; including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students.

Coding-related activities: The activities includes selection, research, and completion of code assignment, querying, other health record data abstraction, data analytics and reporting with codes, coding audits, remote coding, and coding educational activities and functions.

Data: All healthcare data elements including clinical, demographic, and financial.

Page 1 of 6

- Introduction: applies to all who code and all settings!
- Definitions
- 11 Principles
- How to Interpret the Standards of Ethical Coding: Standards and Guidelines
- Footnotes
- Resources

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Standards of Ethical Coding: **Principles**

1. Apply accurate, complete, and consistent coding practices that yield quality data

2. Gather and report all data required for internal and external reporting, in accordance with applicable requirements and data set definitions

3. Assign and report, in any format, only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, and requirements

4. Query and/or consult, as needed, with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices.

5. Refuse to participate in, support, or change reported data and/or narrative titles, billing data, clinical documentation practices, or any coding related activities intended to skew or misrepresent data and their meaning that do not comply with requirements.

Standards of Ethical Coding: **Principles** (cont.)

6. Facilitate, advocate, and collaborate with healthcare professionals in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.

7. Advance coding knowledge and practice through continuing education, including but not limited to meeting continuing education requirements.

8. Maintain the confidentiality of protected health information in accordance with the Code of Ethics.

9. Refuse to participate in the development of coding and coding-related technology that is not designed in accordance with requirements.

10. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.

11. Refuse to participate in and/or conceal unethical coding, data abstraction, query practices, or any inappropriate activities related to coding and address any perceived unethical coding-related practices.

Standard and Guideline #1

Apply accurate, complete, and consistent coding practices that yield quality data.

Coding professionals shall:

1.1. Support selection of appropriate diagnostic, procedure, and other types of health service related codes (e.g., present-on-admission indicator, discharge status).

1.2. Develop and comply with comprehensive internal coding policies and procedures that are consistent with requirements.

Example: Develop internal policies and procedures for the coding function such as Facility Coding Guidelines that do not conflict with the Requirements and use as a framework for the work process, and education and training is provided on their use.

1.3. Foster an environment that supports honest and ethical coding practices resulting in accurate and reliable data.

Example: Regularly discussing the standards of ethical coding at staff meetings.

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Standard and Guideline #1 (cont.)

*Coding professionals **shall not**:*

1.4. Distort or participate in improper preparation, alteration, or suppression of coded information.

Example: Assigning diagnosis and/or procedure codes based on clinical documentation not recognized in requirements (as defined above in the definitions).

1.5. Misrepresent the patient's medical conditions and/or treatment provided, are not supported by the health record documentation.

Example: Permitting coding practices that misrepresent the provider documentation for a given date of service or encounter such as using codes from a previous encounter on the current encounter (except with bundled payment models or other methodologies).

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Standard and Guideline #4

Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices. ***(think of the AHIMA Practice Briefs)***

Coding professionals ***shall****:*

4.1. Participate in the development of query policies that support documentation improvement and meet regulatory, legal, and ethical standards for coding and reporting.

Example: Guidelines for Achieving a Compliant Query Practice (2016 Update)

4.2. Use queries as a communication tool to improve the accuracy of code assignment and the quality of health record documentation.

Example: Designing and adhering to policies regarding the circumstances when providers should be queried to promote complete and accurate coding and complete documentation, regardless of whether reimbursement will be affected.

Example: In some situations a query to the provider will be initiated after the initial completion of the coding due to late documentation, etc., this should be conducted in a timely manner.

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Standard and Guideline #4 (cont.)

4.3 Query with established practice brief guidance when there is conflicting, incomplete, illegible, imprecise, or ambiguous information, (e.g., concurrent, pre-bill, and retrospective).

Coding professionals ***shall not****:*

4.4. Query the provider when there is no clinical information in the health record that necessitates a query.

Example: Querying the provider regarding the presence of gram-negative pneumonia on every pneumonia case/encounter.

4.5. Utilize health record documentation from or in other encounters to generate a provider query.

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Standard and Guideline #11

Refuse to participate in and/or conceal unethical coding, data abstraction, query practices, or any inappropriate activities related to coding and address any perceived unethical coding related practices.

***Coding professionals shall**:*

11.1. Act in a professional and ethical manner at all times.

11.2. Take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

11.3. Be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. These include policies and procedures created by AHIMA, licensing and regulatory bodies, employers, supervisors, agencies, and other professional organizations.

11.4. Seek resolution if there is a belief that a colleague(s) has acted unethically or if there is a belief of incompetence or impairment by discussing concerns with the colleague(s) when feasible and when such discussion is likely to be productive.

Example: Taking action through appropriate formal channels (i.e., internal escalation process or compliance hot line, and/or contact an accreditation or regulatory body, and/or the AHIMA Professional Ethics Committee).

11.5. Consult with a colleague(s) when feasible and assist the colleague(s) in taking remedial action when there is direct knowledge of a health information management colleague's incompetence or impairment.

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Standard and Guideline #11 (cont.)

***Coding professionals shall not**:*

11.6. Participate in, condone, or be associated with dishonesty, fraud and abuse, or deception. A non-exhaustive list of examples includes:

- *Participating in or allowing inappropriate patterns of retrospective documentation to avoid suspension and/or increase reimbursement .*
- *Coding an inappropriate level of service.*
- *Miscoding to avoid conflict with others.*
- *Adding, deleting, and altering health record documentation.*
- *Coding from documentation that is Copied and pasted from another clinician's documentation without identification of the original author and date.*
- *Engaging in and supporting negligent coding practices .*
- *Participating in or allowing inappropriate retrospective provider querying.*
- *Reporting a code for the sake of convenience or to affect reporting for a desired effect on the results*.

Applying the AHIMA Standards of Ethical Coding

- Apply Standards to ALL HEALTHCARE SETTING!
- Ask yourself the question “am I compliant with the Standards of Ethical Coding?”
- Ask the question: “Is my department or organization compliant with the Standards of Ethical Coding?”
- Once you've answered these… determine next steps.
- Awareness and education?
- Employee orientation and new hire orientation to the Standards
- Ask or request that coding auditors utilize the standards
- Request your organization/setting acknowledge and embrace the AHIMA Ethical Standards

Applying the AHIMA Standards of Ethical Coding (cont.)

- **We need to……..Utilize** the “Official” coding resources
  - Review AHA *Coding Clinic*
  - Review AMA *CPT Assistant*
- Seek advice when unsure. . .
- Attend education and conferences to enhance knowledge and understanding.
- Staff meetings and employee orientation
  - New hires
  - Staff meeting once a year
- Coding Roundtables – open dialogue
- Conduct an in-service (include others outside of HIM Coding)
- Even take the standards and share them with others in the Revenue Cycle, in CDI, your internal and external audit staff/teams, with your legal and Compliance department!

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Coding Policies and Procedures

- Coding Policies and Procedures (written) – for all healthcare settings
  - Cover a variety of topics
- Official "Coding Resources" used for the process of coding and for auditing.
  - "Official Guidelines"
- Put into writing the acceptable resources:
  - Current year "Official Coding & Reporting Guidelines"
    - Your department's commitment and adherence to official coding guidelines should be explicitly stated.
  - AHA Coding Clinic
    - ICD-10-CM/PCS
    - HCPCS
  - AMA CPT current book
  - AMA CPT Assistant
  - Merck Manual?
  - Coders Desk Reference?

Official 2018 ICD-10-CM/PCS Coding & Reporting Guidelines: Use this Resource!

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2018
(October 1, 2017 - September 30, 2018)

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2017 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for

- Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings.
- A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
- These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported.
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

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AHA Coding Clinic for ICD-10-CM/PCS: Obtain and Use this Resource!

- Another Coding Professional Required Resource and Guidance
- The AHA Central Office is the publisher of the *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS* and the *AHA Coding Clinic for HCPCS*. *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS* represents a formal cooperative effort between the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) and the Centers for Medicare & Medicaid Services (CMS).

This resource is a MUST for any coding professional no matter what setting they work in.

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Coding Policies and Procedures (cont.)

- Required "Coding Resources"
  - Budget for these . . .
    - AHA Coding Clinic
      - ICD-10-CM/PCS
      - HCPCS
    - AMA CPT Assistant

- While we may not always agree with published advice the Official Coding and Reporting Guidelines and AHA Coding Clinic guidance are the rules that we must follow when reporting ICD-10-CM/PCS codes.

Coding Policies and Procedures (cont.)

- Physician Querying
- Follow the AHIMA Practice Briefs
  - Gold Standard across the industry
- Wording and format – nonleading
- Retain queries
  - Monitor
- Educate on querying

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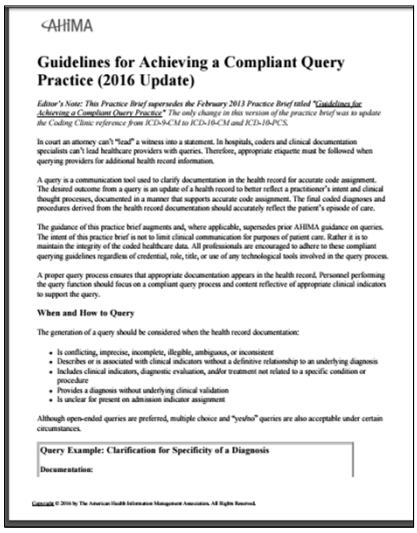
Physician Querying: Gold Standard

- A query is a communication tool used to clarify documentation in the health record for accurate code assignment.
- The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.
- The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.



AHIMA

Guidelines for Achieving a Compliant Query Practice (2016 Update)

Editor's Note: This Practice Brief supersedes the February 2013 Practice Brief titled "Guidelines for Achieving a Compliant Query Practice" The only change in this version of the practice brief was to update the Coding Clinic reference from ICD-9-CM to ICD-10-CM and ICD-10-PCS.

In court an attorney can't "lead" a witness into a statement. In hospitals, coders and clinical documentation specialists can't lead healthcare providers with queries. Therefore, appropriate etiquette must be followed when querying providers for additional health record information.

A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment. The final coded diagnoses and procedures derived from the health record documentation should accurately reflect the patient's episode of care.

The guidance of this practice brief augments and, where applicable, supersedes prior AHIMA guidance on queries. The intent of this practice brief is not to limit clinical communication for purposes of patient care. Rather it is to maintain the integrity of the coded healthcare data. All professionals are encouraged to adhere to these compliant querying guidelines regardless of credential, role, title, or use of any technological tools involved in the query process.

A proper query process ensures that appropriate documentation appears in the health record. Personnel performing the query function should focus on a compliant query process and content reflective of appropriate clinical indicators to support the query.

When and How to Query

The generation of a query should be considered when the health record documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

Although open-ended queries are preferred, multiple choice and "yes/no" queries are also acceptable under certain circumstances.

Query Example: Clarification for Specificity of a Diagnosis

Documentation:

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Coding Policies and Procedures (cont.)

- Coding Education and Maintenance of Credentials
  - Annual coding educational hours
    - Require a minimum
  - Review the continuing education unit requirement for the different coding credentials
    - RHIT
    - CCS
    - CPC
  - Require annual proof of credentials
    - Maintain copies

Coding Policies and Procedures (cont.)

- Coding Education: ongoing
- Hours per year provided or obtained
  - Live-Webinars
  - Face to Face
  - Online – independent
- Support credentials

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Coding Policies and Procedures (cont.)

- Auditing and Monitoring
  - Focused and Random audits: Use OIG Work Plan and Special OIG reports
    - Track all audit findings
    - Trend over time
    - Use findings for future auditing and monitoring work
    - Monitor data: Inpatient and outpatient; ICD-10-CM/PCS and CPT
  - Internal and External
  - Cover all settings
    - Encounter types
  - All Payers
  - Frequency per year
  - Volume of encounters
  - Written report of findings
    - Acknowledge of findings
      - Signature
  - Verbal report of findings (summary)
  - Include corrective action plan
    - Timeline
    - Validate completion

Coding Policies and Procedures (cont.)

- Auditing Results and Action
  - Differences of opinion with results
    - "Final" determination
    - Timely response
  - Action plan
    - Individual responsible
    - Timeline
    - Action – detail
      - Rebilling, etc.
- Quality Department opinions
    - Determination process
    - Timely response

Coding Policies and Procedures (cont.)

- Coding correction and rebilling
  - Corrections
    - Coding changes
      - Impact payment or not?
  - Rebilling
    - Know the 60-day CMS rebilling rule
    - Track all rebilling and VALIDATE completion
      - Remittance Advice (RA) may need to be reviewed
  - Voluntary Disclosure
    - Obtain legal input and guidance

HIPAA and Privacy Within Coding

- Often coding professional email one another regarding a particular scenario or email their manager, etc.
- PHI within these emails needs to be addressed and handled carefully.
- Email is a routine and essential part of communication in healthcare—even when communicating PHI. But setting and enforcing HIPAA-compliant email policies continues to be tricky for many organizations.
- Working from home and maintaining HIPAA compliance and privacy
  - Have a written “work at home” policy
    - Do not allow printing of the medical record

Auditing & Monitoring

- Critical component to Coding Compliance effectiveness
- Written auditing plan and process in place (update annually)
- Frequency of Audits
- Size of record review (10-200?)
- Audit ALL Payers!
- All settings: Inpatient, Outpatient, physician, SNF, Rehab, etc.
- External or Internal or BOTH
- Focused or Random or BOTH
- Written report & communication
- Corrective action plan
  - Date, action and individual responsible

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Clinical Documentation

- Clinical Documentation is foundational to coding.
- Coding audits should also identify missing, incomplete and nonspecific documentation.
- Clinical Documentation Improvement (CDI) should have a mission, goals/objectives, program/process with policies and procedures.
- Follow Ethical CDI Standards
- Have a QA process in place to confirm non-leading queries – both verbal and written. Validate appropriateness of querying and/or missed querying too.
- Interaction and regular communication with HIM Coding.
- All payers . . .

60-day Rebilling Rule (Under ACA)

- **March 23, 2010**: Enactment of the Affordable Care Act (ACA)
  - Section 6402(a) of the ACA (codified at 42 U.S.C. § 1320a-7k(d)) established a new section 1128J(d) of the Social Security Act (the Act), requiring a person that has received an overpayment, to report and return the overpayment by the later of (A) the date which is 60 days after the date on which the overpayment was identified; or (B) the date any corresponding cost report is due, if applicable
  - **Important!** Any overpayment improperly retained by a person after the deadline for reporting and returning an overpayment can result in False Claims Act (FCA) and Civil Monetary Penalties (CMP) liability, and/or exclusion from participation in Federal health care programs

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60-day Rebilling Rule (cont.)

- Report and refund obligations under Section 6402(a) apply broadly to:
  - Providers
  - Suppliers
  - Medicaid Managed Care Organizations
  - Medicare Advantage Organizations
  - Prescription Drug Plan Sponsors

- **Person**: A provider or a supplier (as defined in 42 C.F.R. § 400.202)

- **Overpayment**: Any funds that a person has received or retained under title XVIII of the Act to which the person, after applicable reconciliation, is not entitled under such title
  - "In circumstances where a paid amount exceeds the appropriate payment amount to which a provider or supplier is entitled, the overpayment is the difference between the amount that was paid and that amount that should have been paid."
  - No offset of identified underpayments

PEPPER

- The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a Microsoft Excel file summarizing provider-specific Medicare data statistics for target areas often associated with improper Medicare payments due to billing, DRG coding and/or admission necessity issues. Target areas are determined by the Centers for Medicare & Medicaid Services (CMS).

- Hospitals can use PEPPER to:
  - • Review data for the current quarters (and previous time periods) for each of the areas targeted for improvement by the Centers for Medicare & Medicaid Services (CMS), and compare the hospital's performance to that of the other acute-care PPS hospitals in Texas.
  - • Compare data over time to identify significant changes in billing practices.
  - • Identify areas of potential upcoding and undercoding as well as areas that may be questionable in terms of medical necessity of admission.
  - • Identify areas where length-of-stay is increasing.

CERT

- The Comprehensive Error Rate Testing)program. This postpayment auditing function focuses on billing errors that result from the following:
- Insufficient documentation
- Incorrect coding
- Medical necessity
- No documentation
- Other issues, such as duplicate claims or noncovered services

Know the Targets & Follow the OIG Lead . . .

- Accurate medical records, including electronic health records, or EHR, are the foundation of providing quality healthcare to patients. If an electronic health records company falsely represents that its software has functions that it actually lacks, patient safety could be at risk.
  - **Source: OIG - Eye on Oversight: Electronic Health Records (Video 7/2017)**
- Trastuzumab (Herceptin) JW drug modifier (billing for waste): Specialty Drug Coverage and Reimbursement in Medicaid
  - **Source: OIG Report 10/2017**

Be Effective . . .

- Keep an eye and ear for wrongdoings and abuses of power.
- If something seems wrong, look into it further.
- Report and correct coding (ICD-10-CM/PCS and CPT), including refunding.
- Don't let finances or quality alone drive the coding selection.
- Don't let technology drive the coding selection for reimbursement only.
- Watch for manipulation of the EHR to capture "special" language or wording.
- A new business line? Bring in HIM Coding expert to assess the HIM Coding aspects and readiness
  - Audit and validate during first month of operation!

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Key Next Steps

- Establish "Coding Compliance Oversight"
- Develop, discuss and release a "Code of Ethics"
  - Utilize the AHIMA Standards of ethical coding
- Develop, discuss and release "Coding Policies and Procedures"
- Official Coding Resources
  - Follow and adhere to the "Official Coding & Reporting Guidelines"
  - Obtain and review AHA Coding Clinic each quarter
  - AMA CPT Assistant each month
- Run data reports: Identify patterns and trends

- Some Other Risks to Look Into:
- Higher than Nat'l Avg for MS-DRGs
- Telemedicine
- HCC
- MCC/CC capture rates
- CPT
- Modifiers

Next Steps (cont.)

- Develop and establish "Coding Auditing"
  - Internal and external
  - Audit "coding automation"
    - CAC
    - Inpatient to Profee Dx & CPT
  - Ongoing
  - Rebilling and Corrective Action
- Develop and establish "Coding Education"
  - All Setting
  - All types: ICD-10-CM/PCS, CPT, Modifiers

Summary

- Coding Compliance is real and is a MUST!
- It's best to know targets and areas of weakness of vulnerability.
- Take the 7 key elements and build those into your coding compliance work
- Have policies and procedures in place.
- Educate and Audit
- Ensure your coding compliance program/plan is operational and effective!!
  - Validate the operations and effectiveness

Questions?

- Are there any questions?

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Thank you!

- Thank you for your time today!

References/Resources

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