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HIM Briefings

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INSIDE THIS ISSUE

Coding

Review coding for HCCs

Mastering Hierarchical Condition Categories (HCC) is key to success under new reimbursement methodologies that rely on risk adjustment, quality, and value metrics such as the Quality Payment Program (QPP). However, for many organizations, HCCs haven't been a priority, and that means coders might lack adequate training and education on the topic.

Organizations need to take a close look at their training and audit programs to ensure that valuable information isn't being left out of documentation—and negatively impacting HCC scores.

New reality

HCCs aren't new, but for most organizations their impact hasn't been apparent until recently. HCCs have long been used to calculate risk scores that affect Medicare Advantage payments; however, it's generally the responsibility of the payer to make those calculations. In Medicare Advantage, HCCs are factored in so far down the line that it can be difficult for a provider organization to map cause and effect. For more on HCCs and Medicare Advantage, see the March issue of **HIMB**.

That "out of sight, out of mind" mentality is now changing. Although many Medicare Advantage plans put the organization at a remove from calculations based on HCCs, risk scores are more visible to accountable care organizations (ACO). Additionally, risk scores are set to play a significant role in QPP and Merit-based Incentive Payment System (MIPS) reimbursement. Although the QPP final rule is still on the horizon, providers should already be reporting at least some MIPS measures to avoid negative payment adjustments in 2019.

Savvy organizations are getting their coding and CDI staff up to speed with recent changes and learning about the impact of HCCs, says **Andrea Romero, RHIA,** chief operating officer of himagine Solutions, Inc., in Tampa, Florida.

"The main focus for most healthcare providers now is looking forward to the fourth year of MIPS participation," Romero says, adding that organizations are running a significant risk if they aren't already complying with 2017 MIPS requirements.

The QPP proposed rule includes a provision that would award bonus point categories for practices that treat complex patients. The bonus points would be based on a practice's average HCC risk score. This provision will make capturing risk even more vital, says **James P. Fee, MD, CCS, CCDS,** vice president of Enjoin and hospitalist at Our Lady of the Lake Regional Medical Center in Baton Rouge, Louisiana. "That just stresses the importance of picking up those chronic conditions."

Return on investment

Organizations need to focus on coding and CDI to ensure success, Romero says. Some may require additional education on HCCs and all coders and CDI specialists will need to keep up to date with changes. Initial and ongoing education are investments that will pay off, she adds.

"I think there's a big gap in knowledge of exactly what the impact of HCCs is for MIPS," Romero says. "When you compare relative value units (RVU) to CTPs, it's the same as comparing HCCs with MIPs. I don't think everyone has made that leap in their knowledge of MIPS and the impact it's going to have."

An organization needs to understand what its coders and CDI specialists already know to determine how to target educational opportunities. Performing a thorough review of quality will identify weak spots, Romero says.

"Do an in-depth, deep dive review not only of the quality of the coding now, but also on the quality of your documentation. Make sure they're using the EMRs to the fullest extent," she says. "Make sure that every blank is filled in so they can earn the correct MIPS points."

Staffing

Coding is still a highly competitive job market. Finding and retaining skilled coders isn't easy, and running short-staffed or relying on less experienced coders can hurt an organization, Romero says. That's particularly true when looking for coders familiar with HCCs, she adds.

"It's a very fast-growing area of coding," she says.

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"Being able to find the coders and retain them is a challenge for providers."

Organizations should also ensure they have enough staff to not only correctly code the records but to review all the records for completeness, Romero says. For some payers, the bare minimum documentation doesn't suffice.

For example, if a patient is treated for dementia once in a year and the condition, treatment, and/or ongoing monitoring of the condition is completely documented and coded, the provider could see an increase in reimbursement of $100 per member per month, Romero says.

"Each one of these HCC codes has a direct impact on the physician's bottom line," she says. "It's making sure you have the right staff, ensuring staff has the proper education and resources, and keeping them up to date."

Accurate and productive

Although coder productivity is a critical benchmark, accuracy has a significant impact. A coder who is productive but not accurate can generate a higher than average number of claims that hit denials, sucking up valuable resources to fix denials that could easily have been prevented. On the other hand, a coder who is meticulous but slow to code will produce such a low volume of claims that the benefit of accuracy can be canceled out. Ideally, a coder is both highly accurate and highly productive. However, when establishing benchmarks, evaluating coder performance, and setting departmental goals, HIM professionals can find it difficult to hit the right balance between productivity and accuracy, Romero says.

"My rule of thumb is if you're not doing it right, it's not worth doing," she says. "If you're just rushing through and having someone review charts really quickly rather than a thorough review, physicians are going to miss a tremendous amount of reimbursement."

Now is a good time to take a more deliberate approach, Romero says. All appropriate HCCs should be coded for each patient each year to ensure physicians are getting full reimbursement for their complex patients.

That doesn't mean organizations should throw productivity to the wayside, Romero advises; productivity will remain a cornerstone measurement of coding. However, measuring productivity must become more nuanced and—similar to the way the QPP seeks to balance quality and volume—should take into account the types of charts coders are processing.

"When we look at productivity for our coders, we're looking at the mix of patients that they're reviewing," Romero says. "If it's an inpatient coder, we're looking at the case-mix index, LOS, and DRG prior to making a judgment on the number of charts that should be completed in a given day."

Now might be a good time to evaluate current productivity standards as well as other CDI and auditing processes, Romero says. Take a step back and evaluate how coders are coding, how documentation is completed, and the quality of the documentation.

Ongoing monitoring

A thorough audit will give an organization a detailed picture of its current state of coding and documentation, Romero says. However, finding the staff to perform these audits can be challenging. Internal auditors at most organizations already have their plates full and may not have experience auditing for HCCs.

"This is one of those special projects where most people need some help, as it is a new area of expertise," she notes. "I predict that most organizations are going to have to go outside to ask for help with baseline and ongoing audits."

Regular auditing and education are critical to maintaining accuracy, Romero says. Coding audits should gather information to drive education and monitor the success of education.

"Our main focus is ensuring that our coders are on the cutting edge of all coding changes, that they're the first to know about any coding updates," she says. "We audit them for all different patient types, and we give immediate audit feedback for any findings that we have. We then provide education and monitor their improvement."

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The ultimate goal of auditing is to improve the performance of coders, Romero adds. If auditing is performed simply to check a box on an organization's compliance checklist, the organization is transforming a valuable tool into an administrative function with minimal return on investment.

Using audits to guide education can increase coders' job satisfaction, Romero says. Coding audits can pinpoint the areas a coder is struggling with, letting the organization offer education on specific topics. One-size-fits-all education can seem routine and frustrating, but a coder will likely appreciate education that delivers real value to their careers. Coders, like most professionals, appreciate getting feedback and are more likely to stay with an organization that's interested in helping them meet their full potential.

Training for coders and CDI specialists should also include refreshers on ethics and compliance. As risk-adjustment models come to the forefront, it's likely that regulatory agencies will scrutinize documentation for potential fraud, Fee says.

The Justice Department launched a lawsuit against UnitedHealth in May alleging the organization fraudulently reported HCCs to make its Medicare Advantage patients appear sicker than they really were. It's likely this case will set a precedent for how regulatory agencies monitor and respond to potential fraud in risk-adjustment payment methodologies, Fee says.

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If you are interested in either volunteer opportunity, please contact Editor Nicole Votta at *nvotta@hcpro.com*.

—Nicole Votta, Editor

Defense

Coders, along with CDI specialists, are often an organization's first line of defense against poor documentation, Romero says. She advises bringing coders and CDI specialists together with HIM auditors to create a team that addresses HCC documentation errors. For organizations in risk-adjustment payment models such as ACOs, it's critical that problems are identified and addressed as quickly as possible. The consequences of missing an appropriate HCC can be far-reaching.

"If the documentation of the HCCs or the coding of the HCCs is not present, it's going to impact that physician's reimbursement the following year," Romero says. "For an entire year, it's going to have a negative impact on the physician's reimbursement."

Organizations will be feeling the pinch sooner than some expect, Romero cautions. Data reported in 2017 will have an impact on 2019 reimbursement. Organizations should bring stakeholders, including coders, CDI specialists, and physicians, together to keep these key departments abreast of regulatory changes as well as internal policies and training.

"I think it's important to have a physician leader that's assigned to these projects, especially since it's going to impact clinical documentation and physician behaviors," Romero says. "It's also important to keep CDI and coding involved, especially if you're looking at EHR workflows and the quality of documentation."

Looking ahead

Changes in healthcare delivery and reimbursement have affected every part of the industry—including coding. Ongoing education is a part of life for coders, whether it's annual changes or payment reform.

"Coding continues to change just as healthcare continues to evolve," Romero says. "We have new procedures that we need to understand. We have quarterly *Coding Clinics*, annual ICD-10 coding updates, annual CPT updates. The education process for us never stops."

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Specificity drives FY 2018 codes and reimbursement ramifications: Three changes to understand

by Victoria M. Hernandez, RHIA, CDIP, CCS, CCS-P, AHIMA-approved ICD-10-CM/PCS trainer, and Debi Primeau, RHIA, FAHIMA

The FY 2018 ICD-10-CM changes went into effect October 1. This year there are 363 new codes compared with 3,827 in FY 2017, along with 142 deletions and more than 250 revisions. Though the volume of new codes is relatively small, the impact on reimbursement has the potential to be quite large.

The focus of FY 2018 code changes is specificity. Payers now expect codes to reflect the exact diagnosis and care given before claims will be reimbursed. Increased granularity in both clinical documentation and coding is critical for revenue cycle success in the year ahead. If adequate documentation is not provided, the coder may be forced to use an unspecified code. There is speculation that the use of unspecified codes will result in payers issuing flat-out denials or rejections, which could have major revenue cycle ramifications for an organization.

This article highlights several areas that illustrate the increasing importance of specificity to ensure accurate coding and appropriate reimbursement. Following are three changes that could have revenue cycle ramifications for risk-adjusted payers.

Automatic linkage of coexisting conditions

The term "with" is used in the coding index and table to describe two conditions that are commonly related. These conditions are considered automatically linked together if both are documented in an encounter, unless the provider specifically documents the two are not related. Therefore, coders are empowered to make the connection and code accordingly.

With the FY 2018 update, the word "in" has the same effect as the word "with." Coders now have two terms to automatically link diagnoses together unless the provider documents otherwise. However, automatic linkage still cannot occur if it is expressly prohibited in the guidelines or official advice in Coding Clinic. An example is sepsis with acute organ dysfunction: These two diagnoses cannot be linked automatically unless the provider specifically documents the association.

Myocardial infarction

About 790,000 people suffer a myocardial infarction (MI) each year in the United States. MI is one of the top 10 most expensive hospital principal discharge diagnoses, resulting in annual billings of $11.5 billion (American Heart Association & American Stroke Association, n.d.).

Several new MI codes were introduced this year. There are now specific codes for type 1, 2, 3, 4A, 4B, 4C, and 5 MIs, providing a more accurate picture of chronic and acute conditions and the services used in the patient's care.

Both Medicare and the Affordable Care Act capture MI as a Hierarchical Condition Category (HCC), so we expect reimbursement will be affected across the board. Consequently, specific documentation and clinical indicators must now be present to code an MI. Coders can no longer code an MI strictly from findings noted on

Seven tips to manage annual coding updates

1. Work with your IT team to prioritize and test encoders and all systems that use or are linked to ICD-10 code tables. Make sure all systems are bug-free and operational.
2. Ensure all clinician templates are up to date with new documentation requirements.
3. Review and update physician practice checkoff forms used for billing.
4. Keep the use of unspecified codes to a minimum.
5. Modify query templates for CDI and coders—CDI templates should include clinical indicators.
6. Schedule coding update in-services for all CDI and coding staff. Billing and revenue cycle staff should also receive high-level updates.
7. Share *Coding Clinic* updates with coders and CDI staff immediately upon publication.

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an EKG. Supporting documentation including the patient's symptoms such as shortness of breath or chest pressure must be documented, as well as the associated workup.

Clinical documentation to support medical necessity is mandated and should chronicle exactly what was done for the patient. For example, appropriate MI documentation will include orders for radiology, imaging, EKGs, and/or echocardiograms; the progress notes will also include the rationale for these orders, such as the clinician's thought process.

CMS requires that all orders and progress notes be signed and authenticated by an approved specialty clinician such as a cardiologist or surgeon. No coding changes can be made to a record unless the clinician has documented and authenticated the change.

Substance abuse in remission

The U.S. spends more than $232 billion on healthcare costs relating to abuse of tobacco, alcohol, illicit drugs, and prescription opioids (National Institute on Drug Abuse, 2017). It is therefore no surprise that new codes have been added to further specify substance abuse. The FY 2018 changes include options to code mild alcohol or drug use disorders in remission.

The new codes also define dependence vs. abuse. The new codes fall into an HCC, which can impact reporting and reimbursement for any healthcare organization. If prior substance abuse is documented, coders are urged to review patients' current medications to determine if a remission code is warranted.

For example, a patient may be admitted to an acute care hospital for chronic heart failure with a history of alcohol abuse that is currently in remission and being managed with Antabuse. Since the patient is receiving medication to maintain remission status, the coder should report the code for alcohol use in remission.

Revenue cycle collaboration is key to proper reimbursement

The revenue cycle can no longer be considered separate from patient care. Gone are the days when billers could unilaterally change codes denied on a claim to codes that would pass payer edits. If billers do this today, red flags fly and audits ensue. In the era of greater coding specificity, revenue cycle must collaborate with physicians and HIM to ensure appropriate reimbursement.

Ideally, each organization has at least one physician liaison (PL) who is the key link between the medical staff and all departments involved in the revenue cycle. The PL serves three specific roles:

- Understand the nuances of coding conventions and guidelines, and translate what documentation is required (and why) to obtain the correct code
- Identify areas where CDI and coding teams may need additional education to understand disease processes or how a procedure is performed
- Work closely with the CDI team to develop clinical indicators that identify underlying conditions, adverse effects of drugs, and other key items clinicians should address and document while the patient is in-house

It is equally important for the revenue cycle team to have a close partnership with HIM. This ensures all functional areas are aware of coding changes and compliance issues. Here are four strategies to consider:

- Review all denied claims to determine if a coding or documentation issue caused the error
- Refer all coding or documentation denials to the HIM department for investigation
- Conduct in-service training and provide updates on annual coding guidelines for all revenue cycle staff
- Eliminate unsupported code changes on bills

To mitigate reimbursement risks under the FY 2018 codes, the entire revenue cycle team needs to understand the new changes and how to ensure claims are clean and compliant prior to submission.

EDITOR'S NOTE
Hernandez is an independent consultant specializing in coding, audit, and CDI education. Primeau is president of Primeau Consulting Group in Torrance, California.

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Emergency department E/M levels: Do you have any gaps?

by Vickie Bridge, RHIA, CPHQ

As healthcare professionals, we are accustomed to following protocols, guidelines, standards, and regulations within our respective roles. Currently, there are no national guidelines for how facilities should assign evaluation and management (E/M) levels in the emergency department (ED). Under Medicare's ambulatory payment classification (APC) system, facilities create their own internal guidelines for determining the ED visit level, and each facility must follow its own system to demonstrate compliance. The Federal Register (2000) states:

> *"We will hold each facility accountable for following its own system for assigning the different levels of HCPCS codes. As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill. Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility."*

There are three common methodologies that facilities can consider when establishing visit levels in the ED.

- Staff interventions: Visit level is determined by the number of interventions performed by nursing and ancillary ED staff. Each level is reported based on the number and/or complexity of each intervention.
- Staff time/resource intensity point scoring: Visit level is determined by points allocated to each staff intervention based on time, intensity, and staff type required. The service level is determined by the sum of the points for all services provided.
- Severity acuity point scoring: Visit level is determined by diagnosis codes, the complexity of medical decision-making, or the severity or acuity of the patient's presenting complaint or medical problem.

ED facility visits are assigned using CPT® ED services codes 99281–99285 and, in some instances, critical care codes 99291–99292. The five CPT codes use severity of patient symptoms and intensity of resource use to distinguish levels of ED care. For example, a patient presenting with a sore throat who only requires a quick assessment would be assigned to a Level 1 facility visit level (CPT 99281). In contrast, a patient presenting with chest pain and history of a myocardial infarction who requires constant monitoring would fall into Level 5 (CPT 99285). Note that there is no direct correlation between the facility E/M level and the professional/physician level of service.

CMS also outlined key principles that should be included when establishing ED visit level guidelines. The guidelines should:

- Be based on the nursing and ancillary staff's resource consumption, not the physician's
- Follow the intent of the CPT code descriptor by reasonably linking the intensity of hospital resources used to the different levels of effort represented by the CPT code
- Establish clear guidelines that facilitate accurate payment, can be used for compliance and auditing purposes, and are consistently applied
- Meet HIPAA requirements
- Contain documentation that is only clinically necessary for patient care and based on current hospital documentation requirements (e.g., clear, concise, timely, etc.)
- Not facilitate upcoding or gaming
- Be available for MAC review
- Exclude any service or resource that is "separately billable" by the hospital (e.g., infusions/injections are separately payable and should not be part of the criteria when determining the visit level)
- Not distinguish between new and established patients
- Be usable by all healthcare payers

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Once a facility has established its ED visit level guidelines, it should analyze, on a regular basis, the following questions:

- Are the guidelines based on hospital resources and not physician resources?
- Are there additional resources used in the ED that weren't used when the guidelines were established?
- Has the utilization of resources changed since the guidelines were established?
- Does the clinical documentation support the E/M level assigned by reflecting the severity of the patient symptoms and the intensity of resources used to treat the patient?
- Is there a shift in the severity of patient's symptoms and conditions? Do the current guidelines support the change?
- Is the E/M level assigned accurate?
- Were all the separately billable services charged?
- What is the E/M level distribution and financial impact?

Completing an analysis of a facility's E/M code utilization can pinpoint or resolve systematic gaps with clinical documentation, the capture of separately billable services, and under- or over-assignment of the E/M level. Clinical documentation provides communication amongst all healthcare team members and supports the services rendered to the patient. Clear and concise clinical documentation also aids in the reduction of medical necessity denials. Capturing charges for all separately billed services supports the services rendered during the visit and prevents loss of revenue.

Underassigning or overassigning the E/M level can lead to incorrect payer reimbursement and potential compliance issues. Review your facility's ED E/M guidelines on a regular basis to ensure they reflect the current resources used in the ED, maximize revenue, and close any gaps identified in your analysis.

EDITOR'S NOTE

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REFERENCE

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HIPAA Q&A

by Chris Simons, MS, RHIA

Q It was recently brought to our attention that our hospital should not be returning requests. I am hoping for clarification for when to consider an authorization as valid. I was under the impression that when a request is received from an attorney or record retrieval company on behalf of a patient, certain elements must be present in order to process the request. Along with a patient-signed authorization, there should also be a request letter. Within the authorization, there must be 11 elements for it to be considered valid; otherwise, the authorization and request letter are to be returned until completed. Can you please confirm? The elements listed below are what we understood are required:

- **Patient name**
- **Date of birth/Social Security number (second identifier)**
- **Facility to disclose PHI**
- **To whom PHI may be disclosed**
- **What PHI is to be disclosed/dates of service**
- **Purpose**
- **Redisclosure**
- **Revocation statement**
- **Expiration**
- **Conditioning statement**
- **Signature and date**

We are now being instructed that as long as the patient signs the authorization and it is verified that the patient signed it, the above elements are not required, regardless of who is making the request (i.e., an attorney, record retrieval, etc.). Any guidance or clarification would be greatly appreciated.

A I am not aware that there has been any new guidance from OCR on this. An authorization is required to release PHI for purposes other than treatment, payment, or operations (TPO), or when otherwise required by law. See *http://library.ahima.org/doc?oid=107284#.WeDoO6_rvcs* for a full discussion of the topic. A cover letter is not required.

What you may be referring to is recent guidance that cautioned covered entities (CE) to remove roadblocks to patients receiving their own information. Many organizations do require a release of information when patients request their own information, and they use this for tracking purposes. While there is no harm in requiring a release of information, responding to patients' requests for their own information (or a request made by a legally authorized representative) should not be delayed due to failure to fully fill out an authorization. Technically, an authorization is not required in these cases. In addition, OCR has clarified that charges must be limited as well. Many organizations are changing fees to the $6.50 suggested by OCR or eliminating fees completely when patients request their own records. Remember, the purpose of the authorization is to be sure patients are fully in the driver's seat when it comes to who should be accessing their information for purposes other than TPO.

Q Do we need to have a signed business associate agreement (BAA) with a waste disposal company if they handle waste items that may contain PHI?

A Yes. Because this company is not a CE and it handles your PHI, you need a BAA to make sure the company is notified of its responsibilities regarding PHI protection and what to do in the event of a privacy breach.

Q Does HIPAA prevent patients or patient visitors from taking pictures or video on the premises of our hospital? Are we responsible if a patient or visitor shares a photo or video that shows other patients?

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A This is a complex area, and smartphones are complicating it further. You should certainly do your best to avoid having pictures, audio, or video of patients taken without their consent or when they are incapacitated/unable to consent. There is obviously a big difference between a picture taken in your hospital cafeteria by a visitor and one taken in the operating room while the patient is under anesthesia. Most Americans understand that they are likely to be videoed in a public space, even if it is a hospital waiting room, but they rightly expect privacy when they are receiving medical treatment. Because cell phones are so omnipresent, it is hard to completely avoid this risk, but you should at least try. Staff should not photograph, audiotape, or videotape without patient permission except in certain circumstances (documenting child or elder abuse or taking a photo that doesn't identify the patient, such as a photo of a wound). Remember that your staff also have the right to consent or object to being photographed/videotaped or audiotaped.

Q Can we incorporate state law requirements in our HIPAA Notice of Privacy Practices (NPP), or do we need to give patients two separate forms?

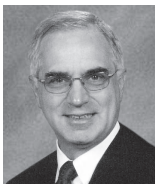
A Two separate forms are not necessary, although not prohibited. The NPP should describe what your organization does with patient information and should accurately reflect your practices. While there are certain basic requirements for the notice (***www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html***), the law does not prohibit additions that reflect your actual practices/state laws.

EDITOR'S NOTE

Simons is the director of health information and privacy officer at Maine General Medical Center in Augusta. Simons is also an **HIMB** advisory board member. This information does not constitute legal advice. Consult legal counsel for answers to specific privacy and security questions. Opinions expressed are that of the author and do not represent HCPro or ACDIS. Send your questions related to HIPAA compliance to Editor Nicole Votta at nvotta@hcpro.com.

A Minute for the Medical Staff

Engage physicians in ICD-10-CM/CPT coding compliance



I would like to write a personal article revolving around one of my very best friends and share with you my experience in addressing documentation and coding compliance.

In September, Dr. John Cauthon, a podiatrist in Murfreesboro, Tennessee, faced his accusers—the United States Department of Justice (DOJ), the Office of Inspector General (OIG), and their expert witnesses—in front of a jury in federal court. The trial addressed allegations that Dr. Cauthon criminally submitted false claims for CPT® code 11730 (nail avulsion) when, according to the government, he had only performed a nail trimming. Due to personal debt, Dr. Cauthon's legal counsel was a federal public defender, one who commonly addresses drug trafficking, kidnapping, and homicide, not the complicated issues of CPT billing, the False Claims Act, or the Civil Monetary Penalties Act.

Although Dr. Cauthon thought he had performed a partial nail avulsion on a multitude of patients, documented it as such, and billed CPT code 11730 according to his documentation of the term "nail avulsion," the plaintiffs opined, based on data mining, that Dr. Cauthon's documentation was clinically invalid and thus fraudulent. Their case held that to perform a nail avulsion, local anesthesia must be administered, yet for billing purposes, the AMA's official reference for coding advice, *CPT Assistant* (December 2002, pages

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6 and 7) states that anesthesia "may" (not "shall") be required. There were technical discussions of what constitutes a nail avulsion, even though for billing purposes, the same *CPT Assistant* clearly details the differences between a partial nail avulsion and a nail trimming or debridement. Of note, there is no national or local coverage determination for Tennessee's MAC guiding the medical necessity or compliant billing of CPT code 11730. Issues other than what Dr. Cauthon was indicted for were introduced to impugn a motive.

Although all seven indictments were for the same issue and Dr. Cauthon was acquitted in three of them, the jury deemed him guilty of criminally fraudulent upcoding in four, essentially making him guilty of them all. From my perspective, if Dr. Cauthon was found innocent in one case, he should have been found innocent in all of them. You can read the DOJ's press release, which was widely circulated in local and national media, here: *www.justice.gov/usao-mdtn/pr/murfreesboro-podiatrist-convicted-16-month-scheme-defraud-medicare-and-other-health.*

While it is true that upcoding constitutes a false claim, otherwise known as abuse, the False Claims Act states upcoding is not fraud unless providers "know" that they are submitting upcoded claims or exercising willful neglect or reckless disregard in their billing practices. All of us would be in jail if the government could use one or two upcoded claims as a foundation for convicting us of criminal guilt.

Upon sentencing, Dr. Cauthon will likely lose his license to practice podiatry (the livelihood he and his children depended on), face prison time of up to 10 years per count, pay substantial penalties of up to $250,000 per count, be placed on the OIG exclusion list (which would prevent him from holding any job, even a nonclinical one, with a healthcare enterprise accepting Medicare and Medicaid funds), and be stigmatized as a criminal and felon. In my opinion, his "crime" was working long hours to see a large volume of patients and not anticipating how the government would interpret the claims he submitted. Dr. Cauthon was left vulnerable because he did not explicitly document his medical judgment as to why the billed avulsions were indicated and how they were performed (as opposed to a nail trimming or debridement); he also failed to take into account the government's perspectives on the billing of foot care in Medicare patients in light of its increased funding for fraud and abuse investigations.

Sadly, Dr. Cauthon is not the only podiatrist who has been caught in this snare. Others listed on the OIG website include:

- Edward Tarka, DPM, involving nail avulsions: *www.justice.gov/usao-ct/pr/norwich-podiatrist-pays-35000-settle-allegations-under-false-claims-act*
- Perrin D. Edwards, DPM, involving nail trimmings: *www.justice.gov/usao-ndny/pr/kinderhook-podiatrist-pleads-guilty-health-care-fraud-pays-410000-resolve-false-claims*
- Michael Thomas, DPM, involving nail trimmings versus debridement: *www.justice.gov/usao-wy/pr/colorado-podiatrist-sentenced-prison-health-care-fraud*

As they say, a good lawyer knows the law while a better lawyer knows the law, the judge, and the jury. Protecting our facilities, providers, and practices against the tremendous power and financial resources of the federal government means that we must have airtight compliance programs and audits that anticipate the perceptions and allegations of the OIG and the DOJ. Keep in mind that along with rooting out the really bad guys, the OIG and DOJ aim to recoup money for the Medicare and Medicaid program and to

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demonstrate a return on the investment the government has made in them. Note that the agencies highlight the $7.70 return for every dollar invested in their efforts between FY 2011 and 2014—$2 higher than when the Health Care Fraud and Abuse Control program began in 1997, evidenced in a press release available at *www.justice.gov/opa/pr/departments-justice-and-health-and-human-services-announce-over-278-billion-returns-joint.*

With that in mind, the OIG has published three documents that are must-reads for physicians and their office and billing staff. These include:

- A model compliance plan for physicians published in the *Federal Register,* available at *https://oig.hhs.gov/authorities/docs/physician.pdf*
- A model compliance plan for third-party billers published in the *Federal Register,* available at *www.oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf*
- An OIG booklet orienting new physicians to fraud and abuse principles, available at *https://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf*

I encourage you to read through these links, highlight what you feel is important, and distribute a printed version to all your physicians and support personnel, even if they appear to be seasoned, ethical providers. If you know of a practice that does not have an active compliance plan, it's OK to obnoxiously insist on following the OIG's road map. You will spare the practice, and yourself, the agony and regret of not anticipating the government's well-financed power to make people's lives miserable.

What are the elements of a written compliance plan? The OIG outlines the following:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

Of course, documentation, coding, and billing is the primary focus of the compliance plan; however, HIPAA and other federal or state laws can also be rolled in. Billing issues to be addressed include:

- Billing for items or services not rendered or not provided as claimed
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary
- Double billing resulting in duplicate payment
- Billing for noncovered services as covered
- Knowingly misusing provider identification numbers, which results in improper billing
- Unbundling (billing for each component of the service instead of using an all-inclusive code)
- Improperly using coding modifiers

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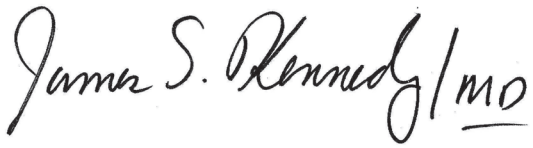
- Clustering
- Upcoding the level of service provided (upcoding is defined by the OIG as "billing for a more expensive service than the one actually performed")

A recently published article in the *New England Journal of Medicine* emphasizes how complete ICD-10-CM coding is essential to success in MACRA, MIPS, and APMs, available at *www.nejm.org/doi/full/10.1056/NEJMp1708084.* I forecast that our ICD-10-CM diagnosis coding affecting MACRA and MIPS will be subject to the same scrutiny that CPT and HCPCS is receiving today.

Physicians may be angry at the increased documentation, coding, and billing workflow and compliance activities they must perform to be successful in these new models. However, for them to avoid what happened to Dr. Cauthon, they'd best develop their own OIG-recommended compliance plan and be open to rigorous feedback and advice. Never underestimate the persuasive power of a government attorney explaining ICD-10-CM and CPT billing to a jury of laypeople. Don't let them do to your providers what they did to Dr. Cauthon.

Thank you for your attention.

With kind regards,



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EDITOR'S NOTE

Dr. Kennedy is a general internist and certified coder, specializing in clinical effectiveness, medical informatics, and clinical documentation and coding improvement strategies. Contact him at 615-479-7021 or at *jkennedy@cdimd.com.* Advice given is general. Opinions expressed are that of the author and do not represent HCPro or ACDIS. Readers should consult professional counsel for specific legal, ethical, clinical, or coding questions. For any other questions, contact Editor Nicole Votta at *nvotta@hcpro.com*.

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Dear **HIM Briefings** subscriber,

The past year or so has brought many exciting changes to **HIM Briefings**—a new name, a new look, a new digital platform, and now a new way to advance your professional education.

We are pleased to announce that **HIM Briefings** will soon offer continuing education credits toward the ACDIS Certified Clinical Documentation Specialist (CCDS) certification. One CCDS continuing education credit will be offered with each quarterly issue (January, April, July, October) beginning with the October 2017 issue.

To obtain your CCDS continuing education credits, you must successfully complete an online continuing education quiz based on the content of that issue. Your certificate will be automatically emailed to you upon successful completion of the quiz.

For questions regarding the quiz, please contact HCPro's customer service department at (877) 727-1728. For more information on ACDIS and the CCDS certification, visit *https://acdis.org/certification*.

We're looking forward to offering you the opportunity to complete your CCDS certification requirements.

Sincerely,

Nicole Votta, Editor
nvotta@hcpro.com

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