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Educational Webinar Series

Mitigating Medical Coding Compliance Risk In Value-based Care

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- Jean P. Delva, RHIA, CDIP, CCS, CCS-P
- Susan Walberg, JD MPA CHC

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Compliance Programs:

Key Activities & Risks

Presented by Susan Walberg, JD, MPA, CHC

Outline

- **What Do Healthcare Organizations Need to Do?**
  - Policies and Procedures
  - Training and Education
  - Auditing and Monitoring
  - Hiring and Discipline
  - Reporting
- **Key Regulatory and Risk Areas to Address**
  - HIPAA Privacy and Security
  - Contracts
  - Fraud and Abuse, Vendor Relations
- **Fraud and Abuse, continued**
  - Anti-Kickback Statute
  - Stark Laws
  - False Claims Act
- **Cases and Enforcement Trends**
- **Conclusion**

Basic Compliance Program Requirements

For any type of healthcare organization, or organizations that partner with healthcare organizations, the following items should be in place (it's also good business!)

- Policies & Procedures
- Compliance Officer/Compliance Plan and Roles
- Training & Education
- Auditing & Monitoring/Corrective Actions
- Hiring & Discipline
- Reporting & Communications

Policies & Standards Of Conduct

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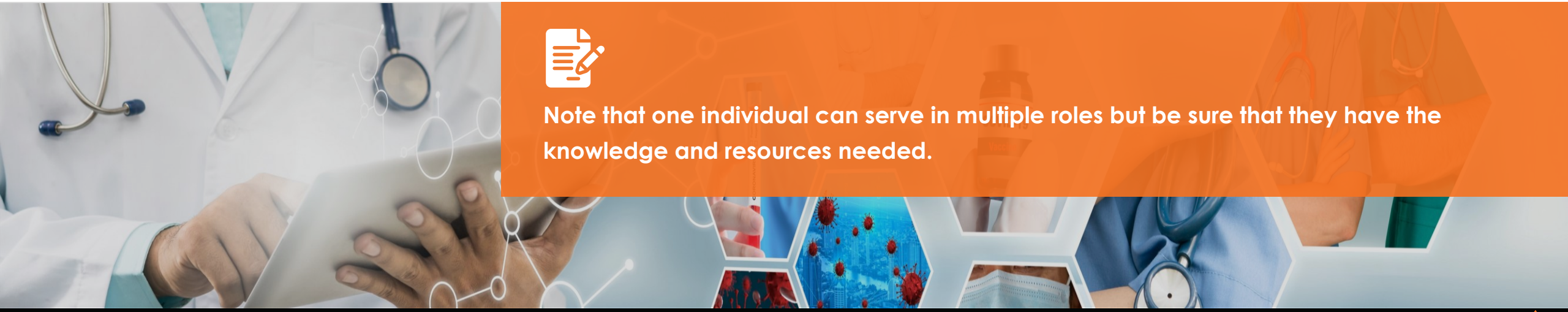
- Define expectations for employees
- Are readily available to all employees, contractors, etc. (via intranet, for example)
- Included in new employee and annual training

Address Key Compliance Risk Areas For The Organization, Such As :

- Billing and Coding
- Contracts and financial arrangements (fraud and abuse)
- Conflicts of Interest
- Privacy and Security (HIPAA)
- Hiring practices and exclusion checking
- Reporting and non-retaliation
- Medical Necessity

Compliance Roles

- Designated Compliance Officer (can be contracted or part-time for smaller organizations). Creates Compliance Plan.
- Compliance Committee (in small organizations, can be the leadership team, but requires dedicated agenda time)
- Designated Privacy and Security Officials (also can be part time or contracted, but is NOT generally part of an IT vendor's duties)
- Don't forget OSHA-Safety Officer should also be designated, if applicable.



Note that one individual can serve in multiple roles but be sure that they have the knowledge and resources needed.

Training & Education

Annual compliance training is expected. Should be documented, and material should be reviewed/updated annually to stay current.

New Employee training, which should also include contracted employees, students, and others working on your behalf.

Risk-specific/Role-specific training, based on your organization's risk areas. For instance, billing and coding presents greater risk and requires additional training. Medical Records staff need additional HIPAA training. Anyone responsible for contracting needs to understand fraud and abuse as well as conflicts of interest issues.

Auditing & Monitoring

Risk assessment and annual audit plans to address key risk areas (billing, security, contracts, for instance)

Monitoring is the routine reviews conducted by operational owners

Auditing is a more formal process whereby someone who DOESN'T own the process conducts a review and provides a report and analysis. Can be internal, but occasional external expert audits are strongly recommended.

Results of all reviews should be provided to the Compliance Officer, and Corrective Action plans generated and implemented. Include actions such as discipline, updated policies, training, improved systems and processes. Follow-up audits to confirm.

Hiring And Discipline

Exclusion checks must be performed for all employees, contractors, and others with key responsibilities. Check the OIG's 'List of Excluded Individuals and Entities' (LEIE) upon hire/contracting and monthly thereafter (or at least quarterly. Monthly is recommended by the OIG)

Background Checks

Discipline policy to include sanctions for compliance violations. Levels of violations should be defined and consistently followed (i.e. unintentional or accidental versus knowing or for personal gain).

Employees understand disciplinary standards

Reporting And Communications

Employees are expected to report compliance concerns as a condition of employment

Company policy to report and that retaliation for reporting is not tolerated. Retaliation should be defined (it's not just termination)

Compliance Officer has 'open door' policy (all leaders should also have an open door to hear concerns)

Other reporting options are optimal, especially for larger organizations (hotline or designated email/phone lines for anonymous reporting).

Confidentiality cannot be guaranteed but should be honored to the extent possible.

All concerns will be investigated by a NEUTRAL party, such as compliance (No fox-guarding-henhouse investigations).

Risk Areas

HIPAA Privacy and Security

Contracts and Vendors

Fraud and abuse laws (False Claims Act, Anti-Kickback Statute, Stark Self-Referral Statute)

New and Emerging Regulations - This is just noted as a reminder- monitor regulatory updates as a normal part of business. CMS, OIG, FTC, etc., all have many free email alert options. Law and consulting firms, also, often have useful blogs and newsletters. All free resources.

HIPAA Privacy & Security

Understand Key Concepts:

- Protected Health Information (PHI) – (what it is)
- Minimum Necessary (what information can be released)
- Authorization Requirements (When and to whom can you release PHI?)
- Business Associate Obligations
- Patient Rights
- Designated Personnel Required (Privacy and Security)
- Technical Security Requirements (Risk Assessment Necessary)
- Training for all staff!

Contracts And Vendors

Many healthcare organizations get in trouble over their financial arrangements. This is a risk area often overlooked. Checks and balances can minimize this risk.

Have an objective process for selecting business partners (conflicts of interest need to be recused).

Legal Counsel should review financial arrangements with physicians especially, but any referral arrangements of government healthcare patients.

All contracts should be in a database that includes key elements:

- Effective and termination date
- Type of arrangement
- Contract Owner

Fraud And Abuse: False Claims Act

The False Claims Act (FCA), 31 USC Section **3729-3733**, provides that "any person who knowingly submitted false claims to the government was liable for three times the governments damages plus civil penalties of **$5,500-$11,000"** for each false claim. (The dollar amount is adjusted from time to time).

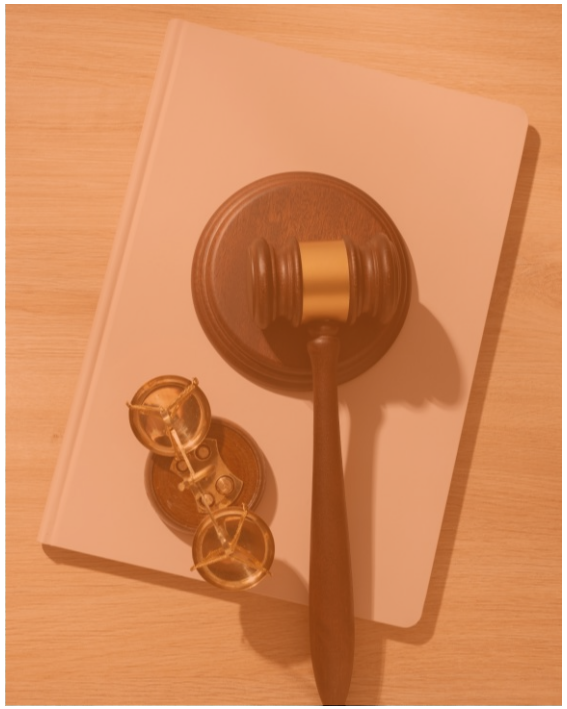
The FCA was enacted in 1863, and grants citizens the right to file civil lawsuits on behalf of the government, allows the government to investigate the claims in secrecy, and allows for significant payments to whistleblowers if the government decides to join the case.

False Claims Act, Cont.

False Claims Act, or FCA, is very broad in its application and enforcement.

FCA liability may be found for any person who knowingly submits a false claim to the government or causes another to submit a false claim to the government or knowingly makes a false record or statement to get a false claim paid by the government.

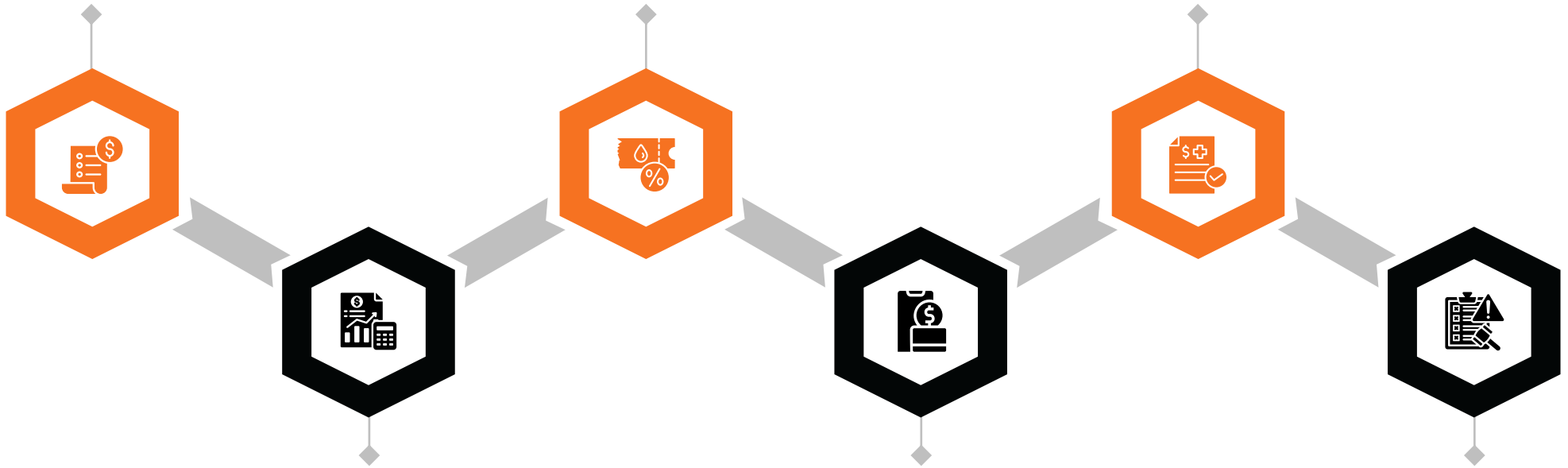
Section 3729(a)(1)(G) is known as the reverse false claims section; it provides liability where one acts improperly – primarily by failing to repay identified overpayments.



False Claims Act, Cont.

Impacted Transactions:

Any transaction where reimbursement flows from a government healthcare program can be subject to the FCA.



False Claims Act, Cont.

Specific Examples:

- Upcoding
- Unbundling
- Inaccurate provider or place of service (that impacts reimbursement)
- Falsified clinical records
- Inflated risk scores
- Vendor rebates that aren't passed along to the Medicare Program
- Any misrepresentations that leads to government reimbursement
- Financial arrangement that may impact clinical judgment
- Failing to timely investigate and repay overpayments from government healthcare programs (no, you can't just fix going forward). Repayment within 60 days of discovery (and confirmation).

Fraud & Abuse: Anti-kickback Statute

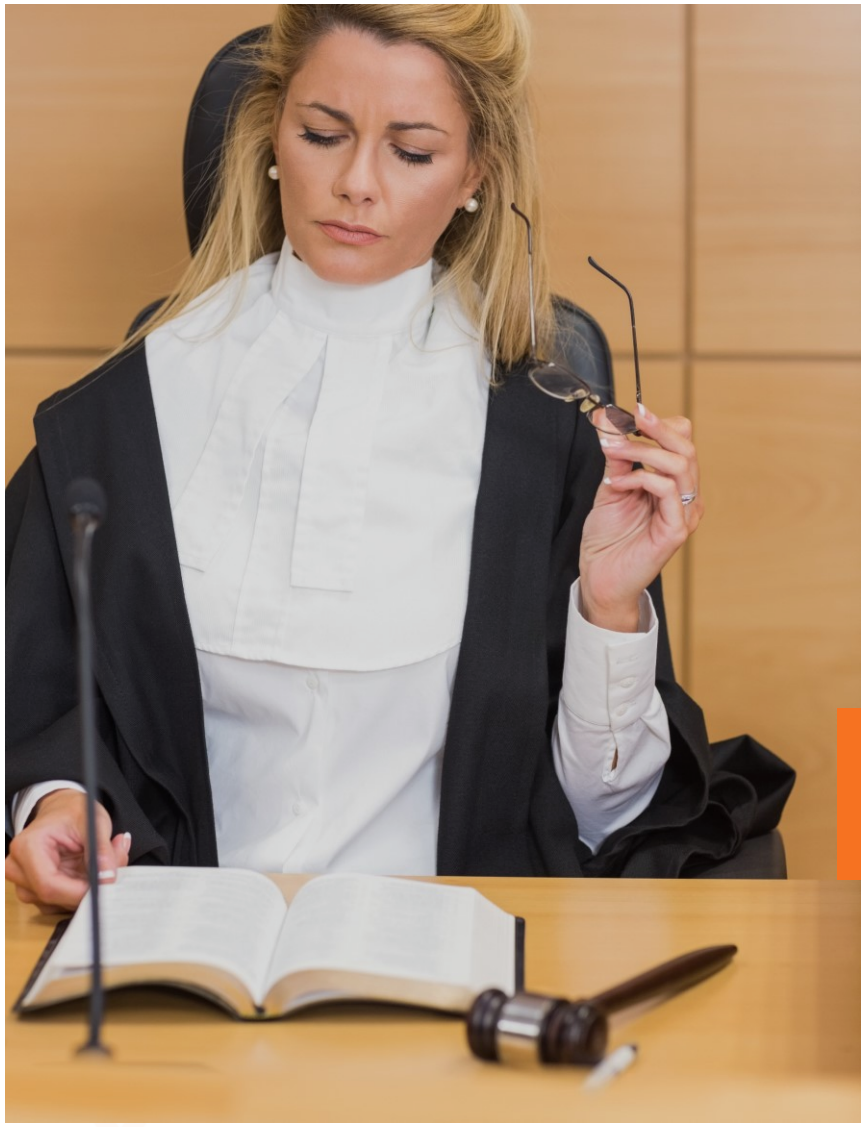
Section 1128B(b) of the Social Security Act

"provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit or receive remuneration in order to induce the referral of business reimbursable under the Federal or State health care programs."

?

What does this mean? We cannot pay or provide free goods or services to referral sources, including things like expensive gifts to physicians or some other significant benefit in exchange for referrals. We also cannot accept gifts to refer healthcare patients to others. **Anything of value can be considered a kickback.**

Fraud and Abuse: Stark Self-Referral Law



Section 1877 of the Social Security Act, also known as the physician self-referral law and commonly referred to as the 'Stark Law'.

Prohibits a physician from making referrals for certain 'designated health services' (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies.

There are a number of exceptions, and criteria that apply, to avoid liability.

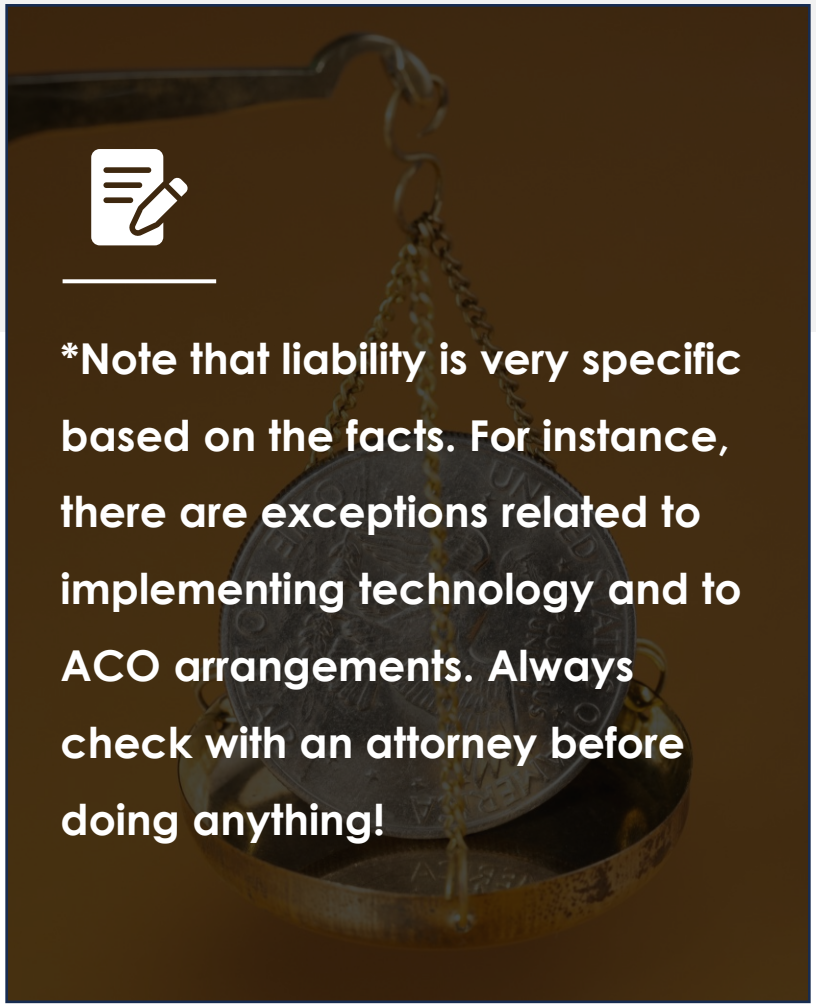
Note that Stark is a strict-liability statute. No Intent is Required!

Consult an attorney with specific healthcare fraud and abuse experience when creating arrangements with physicians.

Penalties

The penalties for violations of these laws can overlap or be combined, as they are often prosecuted together. False Claims Act penalties (treble damages) would apply to Stark or Anti-Kickback, if prosecuted together*. The list below includes the range of possible penalties that can be combined:

- **Anti-Kickback**: Civil or criminal penalties (up to $25,000 per violation)
- **FCA**: Up to $25,076 per instance
- **Stark**: Up to $15,000 per instance
- Exclusion from government healthcare programs
- Treble damages
- Prison



Case in Point: Halifax

Halifax Hospital Medical Center and Halifax Staffing Inc. in Daytona Beach, Florida, was found to have violated the Stark Law in part due to the compensation for certain neurosurgeons and oncologists was linked to the volume and value of patient referrals.

Halifax entered into a settlement agreement with the Department of Justice for **$85 million** and is under a Corporate Integrity Agreement.

Case In Point: Jellybean

Jellybean, The Ultimate Crazy Case!

Jellybean Communications Design created and hosted a website for the federally-funded Florida children's health insurance program. They reportedly failed to secure personal information.

They reached agreement with the Department of Justice to pay **$294,000** to settle the case.

This was a treated as a False Claims Act case. But the violations were HIPAA (Jellybean was a Business Associate) and cybersecurity.

Lesson: The False Claims Act can and will be applied to any 'bad behavior' where the laws don't adequately address the issue.

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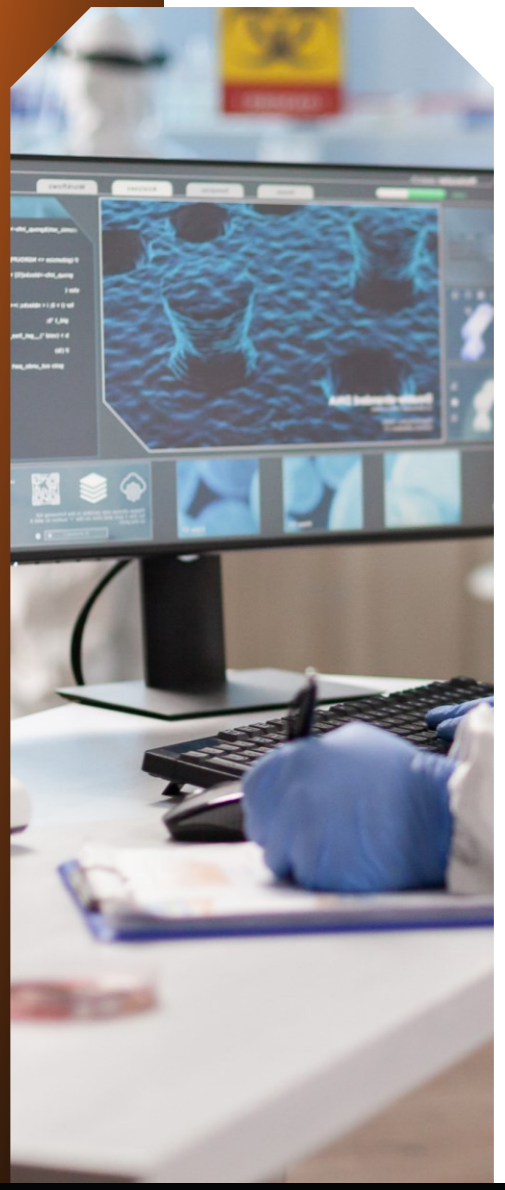

Case In Point: Modernizing Medicine

Modernizing Medicine is an EHR technology vendor that has agreed to pay **$45 million** to resolve Anti-Kickback allegations under the False Claims Act.

In this case, **MM** accepted and provided unlawful remuneration in exchange for referrals and by causing its users to report inaccurate information in connection with claims for federal incentive payments.

This case involved several players and arrangements, thus demonstrating the range of transactions and types of arrangements that can be problematic.

Key Quote From The DOJ:

"Vendors of electronic health records will be held to the same standards of compliance that we expect of everyone who provides health care services."

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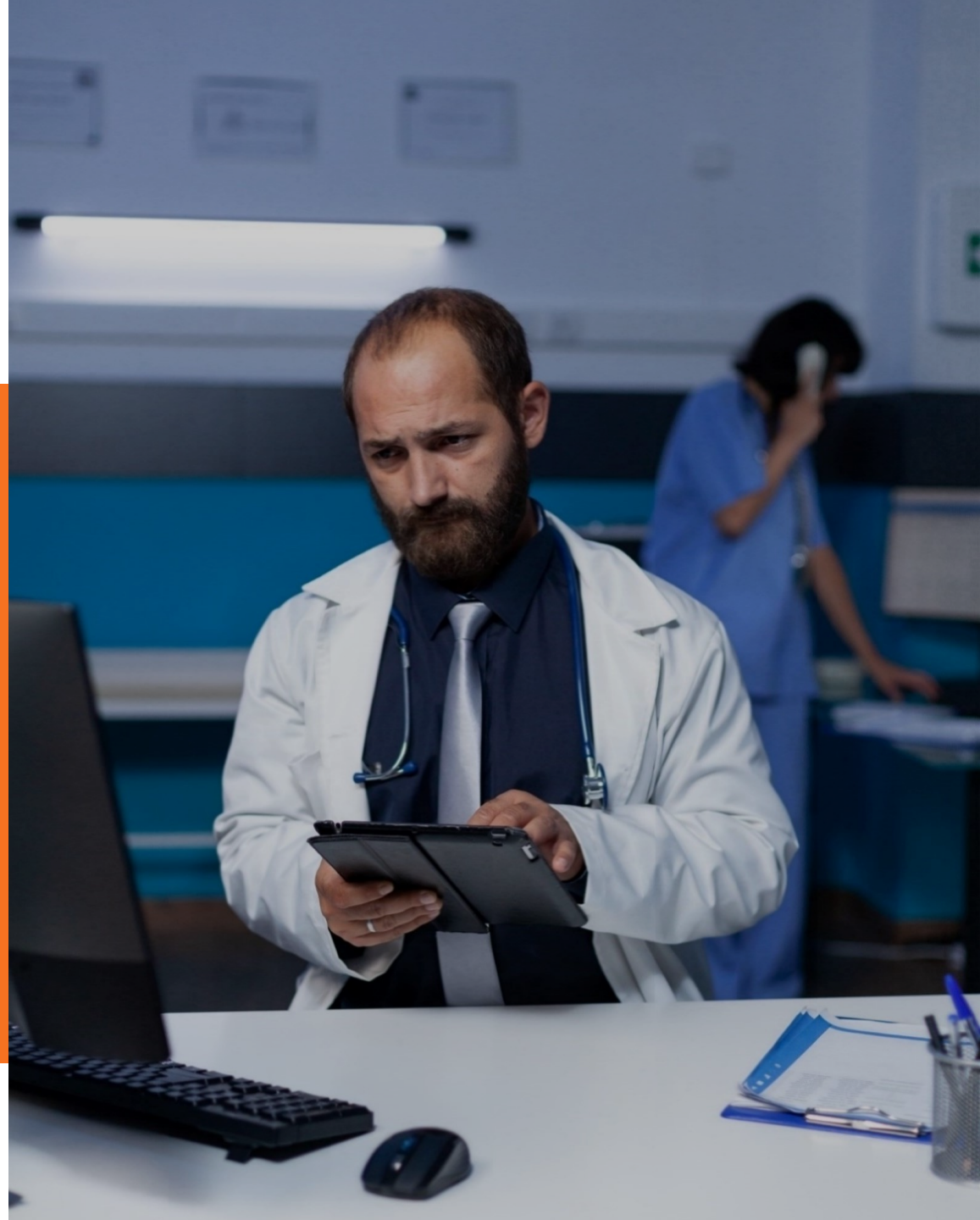
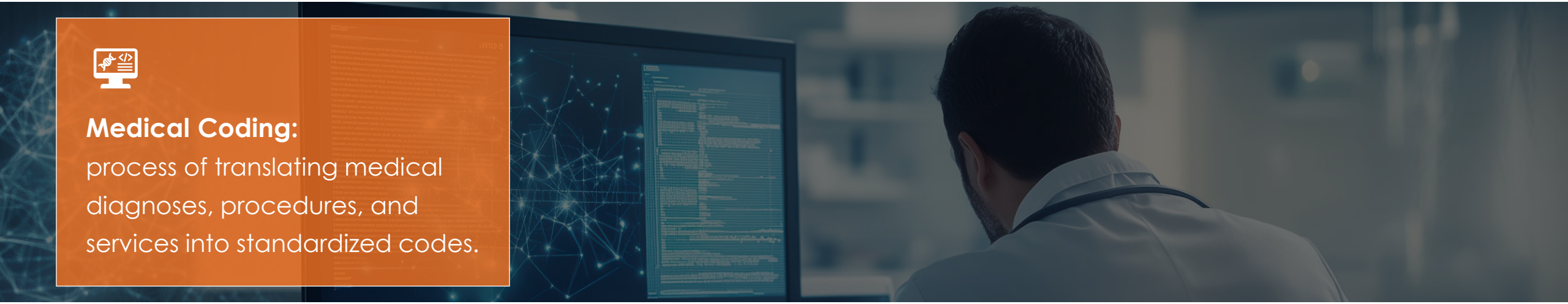
Medical Coder

Jean P. Delva, RHIA, CDIP, CCS, CCS-P



Medical Coding Basics



Medical Coding:
process of translating medical diagnoses, procedures, and services into standardized codes.

Forms The Backbone Of Communication In Healthcare

Reimbursement:
Payers use codes to determine the appropriate reimbursement for services provided

Data Analysis:
Codes allow for the collection and analysis of healthcare data, revealing trends in disease prevalence, treatment effectiveness, and resource utilization

Quality Measurement:
Codes help track and measure quality metrics, ensuring providers meet the standards set for value-based care

Medical Coding Challenges

Vastness And Complexity Of Medical Coding Systems

- Over **69,000** ICD-**10**-CM Codes
- More than **70,000** ICD-**10**-PCS Codes
- Over **10,000** category I CPT codes

Constant Updates Of Medical Coding Guidelines

- This requires coders to stay abreast of these changes and continuously update their knowledge

Ambiguous or Incomplete Medical Records

Inconsistent documentation practices

Common Coding Errors

Undercoding:

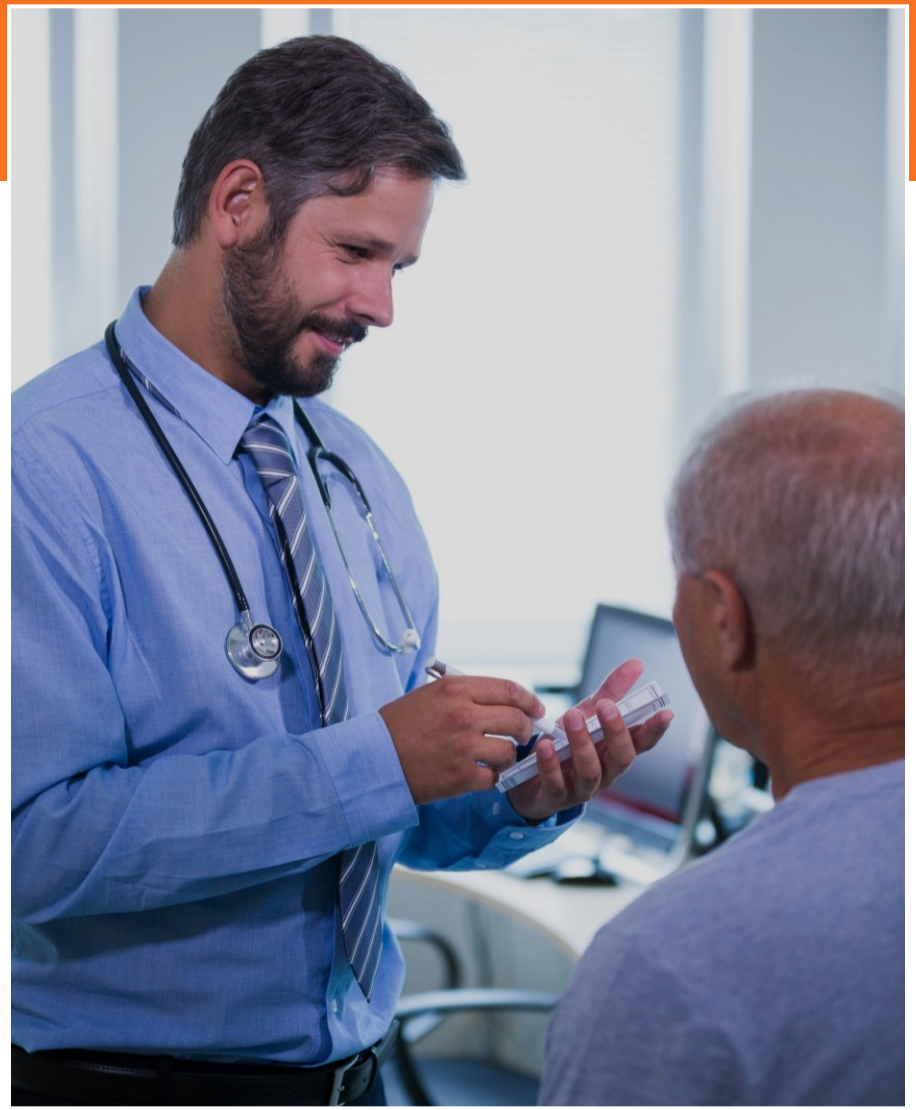
failing to capture all relevant diagnoses and procedures, which can result in lower risk scores and underpayment

Overcoding:

This involves assigning codes for diagnoses or procedures that are not adequately supported by documentation.

- **Unbundling**
- **Unsupported Services**
- **Inaccurate Hierarchical Condition Category (HCC) Coding**

Transitional Care Management (TCM)



Documentation Requirements For TCM

Date Of Discharge:

Date of Interactive Contact:

The date the provider or clinical staff made contact with the patient or caregiver (within 2 business days of discharge).

Date of Face-to-Face Visit:

- Within **7** or **14** days of discharge

Medical Decision-Making complexity:

- Moderate or high

Chronic Care Management

Patient Eligibility And Consent

- Two or more chronic conditions
- Consent
- One provider should be billing for CCM in a given month

Comprehensive Care Plan

- Comprehensive care plan must be established or updated
- Some Key elements:
  - Problem list
  - Measure treatment goals
  - Planned interventions
  - Medication management

Service Delivery And Time

- At least 20 minutes of clinical staff per calendar month dedicated to non-face-to-face CCM services under the direction of medical provider
- Time Tracking: time spent on CCM must be documented accurately, including date, time and type of service provided

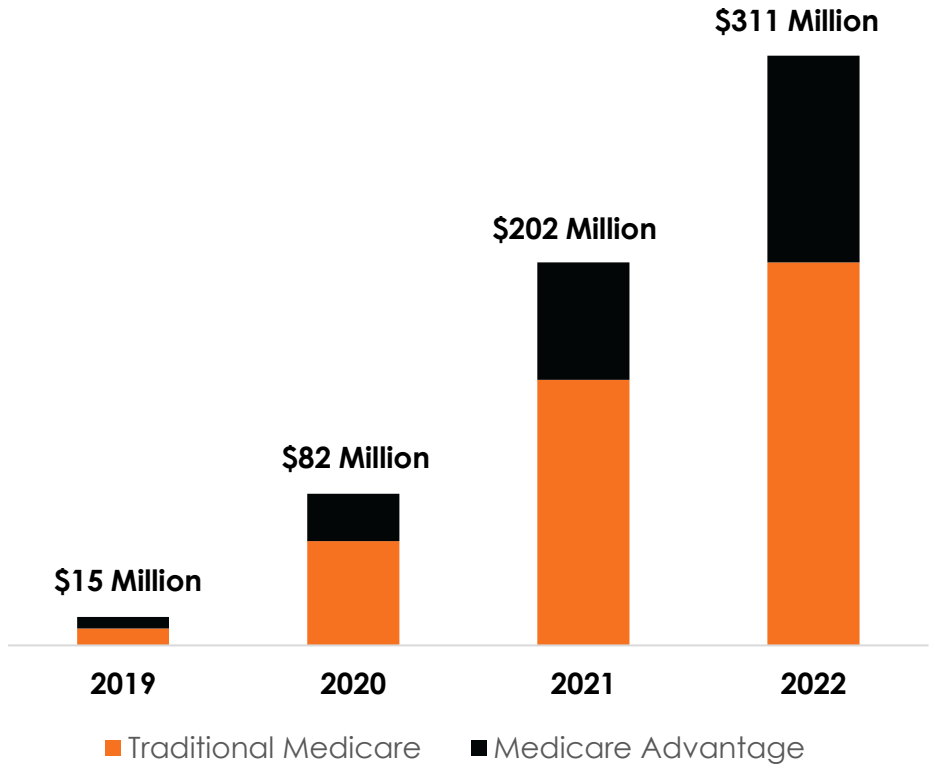
Remote Patient Monitoring

According to latest OIG report, approximately **43** percent of enrollees who received remote patient monitoring did not receive all **3** components of the monitoring, raising questions about whether the monitoring is being used as intended

The Three Key Components Are:

- Enrollee Education and device setup
- Device supply
- Treatment management

Exhibit 1: Payments For Remote Patient Monitoring In Medicare Were More Than 20 Times Higher In Just 4 Years



Source: OIG analysis of Medicare claims and Medicare Advantage encounter data, 2024

Mammogram Screening

The medical record should explicitly state that a "mammogram" was performed

Terms like "breast imaging" or "breast exam" are not sufficient, as they might include other types of imaging besides mammograms.

The documentation should ideally indicate that the mammogram was for "screening" or "routine" purposes

If the exact date is unavailable, the year of the mammogram is sometimes acceptable, but it's best to have the full date.

Inaccurate HCC Coding

Demographics Diseases	HCC	No Conditions Documented	Some Conditions Documented	All Conditions Documented
76-year-old female		0.451	0.451	0.451
Medicaid eligible		0.142	0.142	0.142
DM without complication	19		0.105	
DM with polyneuropathy	18			0.302
Morbid obesity	22		0.250	0.250
Cardiomyopathy	85			0.331
CKD stage 3A	138			0.069
Disease Interaction				0.121
Multiple payment HCC (4)				0.006
Total RAF Score		**0.593**	**0.948**	**1.672**

Leading Query Vs. Non-leading Query Examples

Leading

Progress note dated 8/20/19 shows patient is on oxygen and record shows patient has COPD. If you agree, please consider documenting chronic respiratory failure.

V/S

Non-Leading

Progress note dated 8/20/19 shows patient is on oxygen and record shows patient has COPD. Does patient have one of the following:

- Acute respiratory failure (J96.00)
- Chronic respiratory failure (J96.10)
- Hypoxemia (R09.02)
- Clinically insignificant
- Unable to determine

Leading Query Vs. Non-leading Query Examples

Leading

Lab dated 5/22/19 shows eGFR of 46 and lab dated 6/8/18 shows an eGFR of 58. Please document CKD III.

V/S

Non-Leading

Lab dated 5/22/19 shows eGFR of 46 and lab dated 6/8/18 shows an eGFR of 58. Would you please consider documenting the clinical significance of this finding?

Leading Query Vs. Non-leading Query Examples

Leading

Lower extremity arterial duplex dated 1/16/19 shows diffuse atheromatous intimal thickening and mild scattered nonobstructive plaque throughout the arteries of the right and left lower extremity (2/12/2019; General Point Hospital; CARDIOVASCULAR/US- LOWER EXTREMITY; page 2 of 2). Does patient have atherosclerosis of native arteries of extremities, bilateral legs?

V/S

Non-Leading

Lower extremity arterial duplex dated 1/16/19 shows diffuse atheromatous intimal thickening and mild scattered nonobstructive plaque throughout the arteries of the right and left lower extremity (2/12/2019; General Point Hospital; CARDIOVASCULAR/US- LOWER EXTREMITY; page 2 of 2). Does patient have atherosclerosis of native arteries of extremities, bilateral legs? Yes__ No__, Other (specify)__, Clinically insignificant__, Unable to determine__

Ways To Mitigate Compliance Risk

- Policies and procedures
- Training
- Continuous monitoring
- Assess level of physician engagement in Clinical Documentation Improvement (CDI)

Policies & Procedures

Define Roles And Responsibilities

Outline the roles of CDI specialists, physicians, coders, and other staff. This helps everyone understand their part in accurate documentation and compliant coding

Establish Query Guidelines

Set clear, evidence-based standards for query formulation focused on clinical clarification

Prohibit queries aimed solely at coding or reimbursement

Define channels for query communication and response times

Emphasize Ethical Conduct

Include a code of ethics that prohibits any activity that could compromise the accuracy or integrity of the medical record.

Outline the consequences of non-compliance, including disciplinary action or termination

CDI Training

Tailor training to specific role

Training should be ongoing

Evaluate training effectiveness

If your hospital is a teaching facility, incorporate CDI training early in residency (intern year and beyond)

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CDI Training For CDI Specialists

- Coding and Documentation Guidelines
- Query Best Practices
- Ethical Conduct
- Communication Skills

CDI Training For Medical Providers

Documentation Requirements

Query Response

CDI Program Goals

CDI Training For Other Staff (Coders, Billers, Etc.)

Coding guidelines

Documentation requirements

Compliance awareness

Continuous Monitoring

Detects Coding & Documentation Errors

Identifies Query Misuse

Regularly review a sample of CDI queries and physician responses to assess their compliance with established guidelines and identify any inappropriate practices.

Assesses CDI Specialist Performance

Uncovers Trends and Patterns

Utilize data analytics tools to track key performance indicators (KPIs) related to CDI activities, such as query response rates, coding changes, and financial impact.

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The Physician's Perspective

Jose Guethon MD MBA CDIP (AHIMA)

Medical Necessity & Clinical Documentation

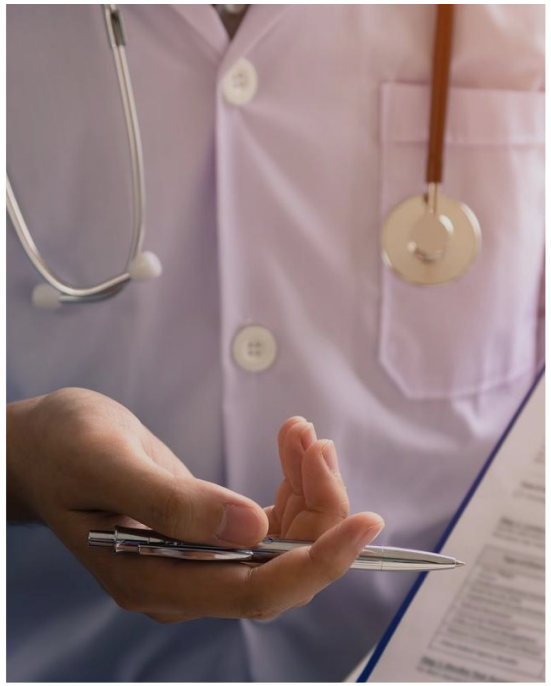
Proper documentation is essential for proper utilization, continuity of care, quality of care, and compliance. "The struggle is real."

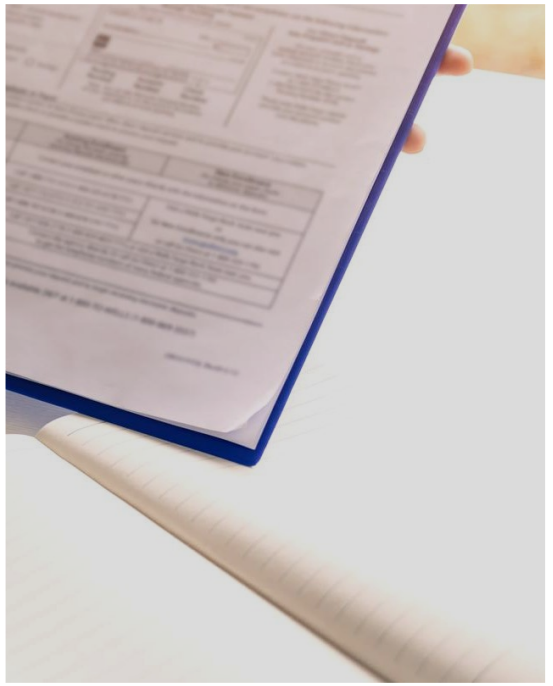
The financial health of the organization is at stake.

Appropriate resource utilization depends on proper medical necessity and documentation.

"Uncontrolled variation is the enemy of quality" (Basic Statistical Tools For Improving Quality, Deming)

"The physician's brain is not always connected to the pen" (Guethon)





Different Approaches/Tools

DSP- Diagnosis, Status, Plan

MUSIC- Manifestation, Underlying causes, Severity or Specificity, Instigating (precipitating) factors, Consequences or complications

TAMPER ™- Treatment, Assessment, Monitor, Plan, Evaluation, Referral

MEAT- Monitor, Evaluate, Assess/Address, Treatment

Ethical Considerations

Collaborate on developing ethical clinical standards across the organization (credibility & standardization)

Follow ethical standards for provider queries (policies and procedures)

Non-compliance is a significant business risk (medical malpractice and audit liability)

Physician-Coder Collaboration

- CDI takes a village, and everyone plays a role
- Collaboration and communication are the foundations for an effective CDI program
- Physicians need to understand and appreciate the roles of the different coding professionals
- Coding professionals need to understand and be sensitive to the demands on physicians
- Create an environment of respect and positive engagement; education is a two-way street (physician engagement can be an open door or a barrier)

The Impact of Patient Care

Direct clinical care (diagnosis leads to treatment)

Better recognition of patient comorbidities and severity of illness

Improved patient outcomes

Decreased risk of conversion to an observation stay

Physician quality scores and how coding defines the expected LOS, core measures, hospital-acquired conditions, and patient safety indicators

Performance metrics-utilization of the severity of illness and risk of mortality

Any Questions? ?

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