Part III Objectives

- ability to understand;
- Compliance laws relating to coding,
- Ethical dilemmas in coding, and
- Coding standards
- Credentials
  - CCA
  - CCS
  - CCS-P

4/20/07 Schedule

- 10 am – 10:05
  - Introductions/Overview of day
- 10:05 – 10:50
  - Coding Compliance
- 10:50 – 11 am Break
- 11:00 – 11:45
  - Coding Ethics/Standards
  - Coding Credentials
- 11:45- 12:00 noon
  - Questions
Coding Compliance
- Hospitals must establish adequate internal control procedures to ensure that claims are submitted accurately
  - edits (unbundled codes, wrong codes, pt age/sex)
  - compliance warnings (upcoding)
  - reimbursement (legitimate reimbursement opportunities - optimal)
- Audits (100% retrospective review, external) and reporting
- Monitoring (concurrent sample, internal), tracking data flow
- Continuing Education/Training

HIPAA of 1996
- Created Health Care Fraud and Abuse Control Program
  - for MC, MA, and private industry
  - OIG and Dept of Justice have power to
    - enforce federal, state, and local laws to control healthcare fraud and abuse
    - conduct investigations and audits pertaining to delivery and payments for healthcare services

HIPAA penalties
- Criminal penalties for providers who “knowingly and willfully” attempt defraud
  - up to 10 years in prison
  - up to 20 years if serious injury to pt
  - up to life if death of patient results
HIPAA penalties
- Civil penalties –
- $10,000 for EACH item or service billed fraudulently
- levied against providers, not individual employees

HIPAA fraudulent activities
- 2 new practices added to civil fraudulent activities
  - engaging in a pattern of coding that the person knows or should know will result in inappropriately higher payments (unbundling, fragmenting)
  - submitting a claim for a medical item or service that the person knows or should know is not medically necessary

Coder knows or should know
- How do you know every rule & regulation?
- US Govt publishes all proposed and final rules & regulations in daily Federal Register
- Therefore you have been told and you are now responsible!
Assumption Coding
- Assignment of codes based on assuming (after review of the record) that pt has certain dx or requires certain proc w/o specific documentation by provider
- Types of Assumption Coding
  - Unbundling
  - Upcoding
  - Overcoding
  - Jamming
  - Downcoding

Types of Assumption Coding
- **Unbundling:** reporting multiple codes when a combination code exists
- **Upcoding:** reporting codes not supported by documentation
- **Overcoding:** reported codes for signs, symptoms, AND established diagnosis
- **Jamming:** routinely assigning 0 or 9 as 4th or 5th digit instead of the appropriate code (coding from the index)
- **Downcoding:** reporting lower-level codes as a convenience

Avoid Assumption Coding
- Assignment of codes based on assuming (after review of the record) that pt has certain dx or requires certain proc. w/o specific documentation by provider
- Creates risk of fraud and abuse
- Need to use physician query process
- Physician Query Guidelines
**Physician Query Process**

- Query based on clinical documentation
- Concurrent or Retrospective?
- Designate Contact person for process
- Use a query form
- Ask open-ended questions to avoid “leading” the physician
- Decide how to file
  - Part of record = subject to disclosure
  - Administrative = not subject to disclosure
- Need Dr documentation addendum in MR

**Physician Query Forms**

- To obtain copies of sample physician queries and procedures, sample physician query forms, and physician query and medical record addendum forms, visit MC QIO for Oregon (OMPRO) Web site at [www.ompro.org](http://www.ompro.org), click on “Coding and Documentation Resources.”

**Physician Query???

- Pt admitted with SOB, chest pain, fever
- PE – rhonchi, wheezing, rales
- Lab – sputum culture shows gram-negative bacteria
- Final dx – viral pneumonia
- Should coder assign 480.9 or 482.83?
- Do you need to complete Physician Query?
$ consequences in Inpt

- 480.9 = about $2,500
- 482.83 = about $3,500
- Loss of $1,000 to facility

Example

- Pt presents to ED w/CC of severe facial pain and headache
- Radiologist interpretation of x-ray is frontal sinusitis
- ED Dr documents dx of headache, facial pain, and sinusitis
- You should code?

Example

- Pt present to Dr’s office w/CC of nose lesion
- Lesion is removed in office and sent to path
- Pt scheduled for appt in 2 weeks
- Dx is “lesion of the nose”
- Path report is in record when coded
- Pathologist document “actinic keratosis”
- You should code?
Basic ICD-9-CM Coding
Part III Compliance & Stds
April 20, 2007 10 am – 12 noon MST
Irene Mueller, EdD, RHIA
Montana Hospital Association
Tele-Video MT-NC
Spring 2007

Break Time

Coding Ethics/Standards
• Coders represented in the Cooperating Parties by AHIMA
• As professionals have code of standards
• Credentialing process
  – CCA (entry-level coder)
  – CCS, CCS-P
  – RHIT (CCA)
  – RHIA (CCA)
• continuing education mandatory

Irene Mueller, MLS, RHIA
HC Ethics

- Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.
  - Hippocrates, 460 BC
- Source: [http://www.sjsu.edu/depts/Museum/hippoc.html](http://www.sjsu.edu/depts/Museum/hippoc.html)
- Accessed: 2/13/07

AHIMA Code of Ethics

Advocate, uphold and defend the individual’s right to privacy and the doctrine of confidentiality in the use and disclosure of information.

Put service and the health and welfare of persons before self-interest and conduct themselves in the practice of the profession so as to bring honor to themselves, their peers, and to the health information management profession.

Preserve, protect, and secure personal health information in any form or medium and hold in the highest regard the contents of the records and other information of a confidential nature, taking into account the applicable statutes and regulations. [www.AHIMA.org](http://www.AHIMA.org)

AHIMA Stds of Ethical Coding

- In this era of payment based on diagnostic and procedural coding, the professional ethics of coding professionals continue to be challenged. A conscientious goal for coding and maintaining a quality database is accurate clinical and statistical data. The following standards of ethical coding, developed by AHIMA's Coding Policy and Strategy Committee and approved by AHIMA's Board of Directors, are offered to guide coding professionals in this process.
Compliance vs. Ethics
• How are ethics different from compliance?
• Ethics encourage good conduct. They are based on self-imposed standards, such as a Code. An ethics program is motivated by self-improvement and is based on principles and values. It seeks to help define “what you should do.”
• Compliance programs strive to prevent bad or criminal behavior. Because legal compliance is the goal, compliance programs are usually externally imposed. The motivation is to avoid penalties and punishment, and the reinforcement is all about what you can’t do.

Compliance vs. Ethics
Compliance programs are the floor, not the ceiling.
They outline minimal behaviors, not the best – there may still be room for unethical conduct. Compliance programs rarely address the root causes of misconduct, and they don’t inspire human excellence. HIM professionals are actively involved in our organization’s compliance programs. We need to understand, however, that ultimately, we should be striving for organizationwide ethics programs for our healthcare organizations.
Enlightened healthcare organizations are going beyond compliance by encouraging an ethics program.

AHIMA Coding Credentials
• Credentialing process
  – CCA (entry-level coder)
  – CCS, CCS-P
  – RHIT (CCA)
  – RHIA (CCA)
  – continuing education mandatory
• http://www.ahima.org/certification/
CCA

- The CCA should be viewed as the **starting point** for an individual entering a new career as a coder. The CCS and/or CCS-P exams demonstrate the mastery level skills that the CCA would strive for to advance his or her career.

CCA Competencies

- Health Records and Data Content
- HI Requirements and Stds
- Clinical Classification Systems
- Reimbursement Methodologies
- Information and Communication Technologies
- Privacy, Confidentiality, Legal, and Ethical Issues

Clinical Classification Systems

- Utilize electronic applications (encoders)
- Assign principal or 1st-listed ICD-9-CM codes
- Assign 2ndary dx ICD-9-CM codes, including CCs
- Assign principal and 2ndary procedures
- Assign procedure codes using CPT
- Assign appropriate HCPCS codes
- ID discrepancies between coded data & supporting documentation
- Consult reference materials to facilitate code assign.
### CCS
- Certified Coding Specialists are professionals skilled in classifying medical data from patient records, generally in the hospital setting. They review patients’ records and assign numeric codes for each diagnosis and procedure.
- They must possess expertise in ICD-9-CM and the surgery section of CPT. In addition, CCSs know medical terminology, disease processes, and pharmacology.
- Accordingly, the CCS credential demonstrates tested data quality and integrity skills in a coding practitioner. The CCS certification exam assesses **mastery or proficiency** in coding rather than entry-level skills.

### CCS-P
- The CCS-P has expertise in physician-based settings such as physician offices, group practices, multi-specialty clinics, or specialty centers.
- A CCS-P reviews patients’ records and assigns codes for diagnoses and procedures, which requires in-depth knowledge of CPT and familiarity with ICD-9-CM and HCPCS Level II coding.
- The CCS-P is expert in HI documentation, data integrity, and quality. Because coded data are submitted to insurance companies or the government for reimbursement, the CCS-P plays a critical role in the health provider’s business operation.
- The CCS-P certification exam assesses **mastery or proficiency** in coding rather than entry-level skills.

### How did you code the Goofy MR?

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Question from last time

- We had a question from one of our MDS nurses regarding a diagnosis of Sundowner's Syndrome? We were wondering if the code 296.90 would be the correct code to use? Thanks for your help.

People with diseases such as Alzheimer's often have behavior problems in the late afternoon and evening. They may become demanding, suspicious, upset or disoriented, see or hear things that are not there and believe things that aren't true. Or they may pace or wander around the house when others are sleeping.

http://www.alzla.org/dementia/sundowning.html Alzheimer's Assoc of LA

Sundown Syndrome

- Experts suspect that the problem of late afternoon confusion, which is sometimes called "sundowning," or "sundown syndrome," may be due to these factors: An Alzheimer pt
- can't see well in dim light & becomes confused, or
- may have a hormone imbalance or a disturbance in his/her "biological clock," or
- gets tired at the end of the day and is less able to cope with stress, or
- is involved in activities all day long and grows restless if there's nothing to do in the late afternoon or evening.
- A caregiver can communicate fatigue &stress to the Alzheimer patient and the person becomes anxious.
Sundown Syndrome

• Since this is a manifestation of dementia, does the patient have a diagnosis of some kind of dementia? Before we complete coding, I need to know if there is a dx of dementia?

• What is the difference between follow-up, status, examination? I have a hard time on these, because the doctors will put down status of something and I never find the code there, but I will under Follow-up, Examination and sometimes under Aftercare?

• So when do you use these? Or what are the definitions of these to maybe help me know when they should be used.

Logistics

• Please complete the evaluation form

• Questions about ICD-9-CM diagnosis coding sent to my email through May 1st, will be answered