Coding Compliance Deep Dive

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Resources

- AMA
- CMS
- AHA
- OIG
- RBMA

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Disclaimer

The information presented is based on the experience and interpretation of the presenters. Though all of the information has been carefully researched and checked for accuracy and completeness, ADVOCATE does not accept any responsibility or liability with regard to errors, omissions, misuse or misinterpretation.

Agenda

- Coding compliance through the revenue cycle
- Important topics:
  - Ordering rules
  - The radiology report
  - Coding guidelines
  - Coverage & denials
- Regulatory considerations
  - Governing Bodies
  - Noncompliance/Penalties
  - Compliance Laws
  - Case Review
- Risks and Benefits
- Q&A

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Coding Compliance Through the Revenue Cycle

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ORDERING RULES

- Testing Facility/Global site vs. hospital
- Testing Facility/Global Site:
  - CMS Order Requirements for Diagnostic Tests (*Medicare Benefit Policy Manual-Ch 15 Section 80.6)*
  - What constitutes an order?
  - Treating physician
  - Conditional orders
  - Performing a different study/additional study than ordered
  - Test Design
- Hospital-Professional Billing Only:
  - Radiologist may add/modify test as they see fit as long as they have hospital privileges and it is medically necessary
  - Usually governed by hospital's policies and medical staff bylaws

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THE RADIOLOGY REPORT

- Legal Source Document
  - *"Provider documentation serves as evidence of the provision of services, who provided the care, the medical necessity, and the quality of care"* (AMA)
- ACR Practice Guidelines for Communication of Findings
- Required for appropriate CPT and ICD-10 code assignment
- Quality Payment Program (QPP)
- Legal/Malpractice

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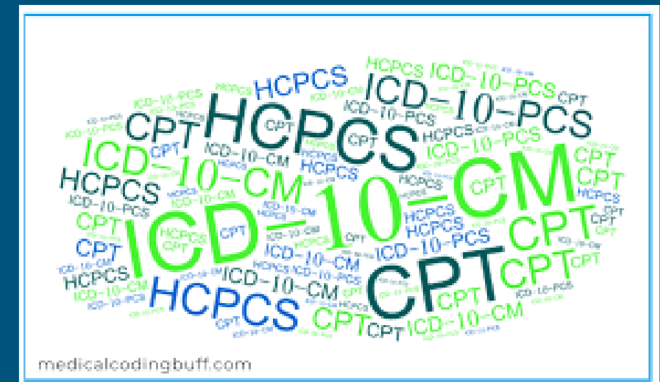
CODING GUIDELINES

- CODING CLASSIFICATIONS:
  - American Medical Association (AMA): CPT
  - American Hospital Association (AHA): ICD-10-CM
- GUIDANCE:
  - Payer Guidelines/CMS/NCCI
  - AMA/AHA
  - Society Guidelines-ACR/SIR/SNM
  - Third party/Consulting/Forums
- ALWAYS DOCUMENT YOUR POLICY!



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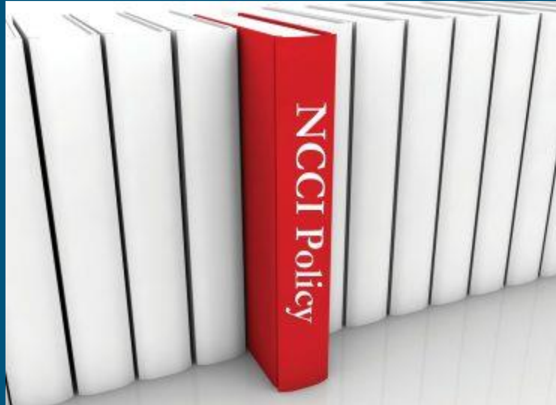
NATIONAL CORRECT CODING INITIATIVE



- Uniform Payment Policies
- Policy Manual
  - Radiology-Chapter 9
- NCCI Edits
  - Procedure to Procedure (PTP)
    - Modifier -59/EPSU Modifiers (EPSU modifiers) when appropriate
  - Medically Unlikely (MUE)
- Same provider/specialty within a group & same DOS

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CODING GUIDELINES

- Areas of Focus:
  - Upcoding/Downcoding
  - Unbundling
  - Appropriate use of modifiers
  - Appropriate use of unlisted codes

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COVERAGE & DENIALS

- Audits:
  - Retroactive Audits
  - Utilization Review
  - Overpayment/Takeback
- Denials:
  - Bundling
  - Global Period
  - Frequency
  - Medical Necessity

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MEDICAL NECESSITY

“Can you just tell me what to say to get this paid?”

- Medicare Coverage Database (MCD)
  - Billing & Coding Articles
  - National Coverage Decisions

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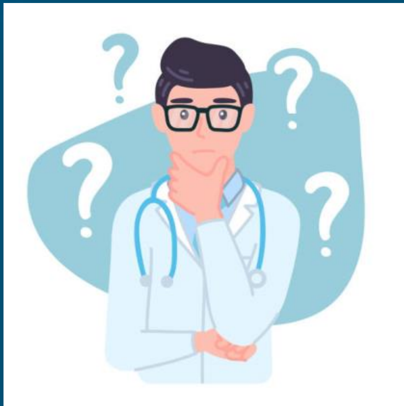
The Provider Perspective



- Clinical-Patient Care
- Want to clearly communicate to colleagues
- Want to be compliant
- Want to be accurately and fairly reimbursed for their work

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REGULATORY CONSIDERATIONS

- Who establishes coding and billing rules
  - Department of Health & Human Services (DHS) primarily, along with other state or federal agencies and programs, such as
    - CMS – Centers for Medicare & Medicaid
    - OIG – Office of Inspector General
    - OCR - power to issue financial penalties and correction action plans
    - DOJ & FBI – conduct investigate and enforcement actions
    - Non-governmental entities
    - American Medical Association Editorial Panel (AMA)
  - Maintains and provides guidance on Current Procedural Terminology (CPT) codes

- Purpose
  - Establish standards and best practice for coding systems used in medical billing and coding
  - Consistency & fair treatment of patients in billing practices
  - Correct billing and payment for services rendered
  - Timely payment to providers
  - To prevent fraud and abuse by healthcare providers
  - Statistics, tracking and data collection

- Definition of Coding Compliance
  - The process of ensuring that diagnosis coding, procedure coding and relevant data is compliant with all established rules, laws and guidelines.

Penalties for Non-Compliance

- Penalties may be either civil or criminal in nature
- Governing laws may derive from
  - Federal or State laws or Statutes
- Damaging Effects - may trigger
  - Burdensome governmental audits, medical necessity review, claim recoupment
  - Extended review and scrutiny by government payers
  - Loss of payer or other vendor contracts (breach of contractual obligations)
  - Loss of the three R's - valuable Resources, Revenue, Reputation
  - Exclusion from Medicare
- OIG may exclude anyone who has
  - Engaged in abusive billing practices
  - Hires or does business with anyone who is an excluded individual or entity (LEIE/SAMS)
  - Includes compliance with HIPAA

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Compliance Laws

- **Physician Self-Referral Law, Ethics in Patient Referrals Acti (Stark Law)**
  - Prohibits a physician from making a referral of a Medicare/Medicaid patient to an entity for the furnishing of "designated health services" payable by Medicare or Medicaid from an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless an exception applies.
    - A financial relationship includes having an ownership interest, a financial investment in, or a compensation arrangement with an entity
    - Prohibited referrals may not be billed
    - **Example:** A physician refers a patient for services only to pharmacies, hospitals or service locations where the physician has an ownership or financial interest
- **Anti-Kickback Statute (AKS) 42 U.S.C. §1320a-7b(b)**
  - Is a criminal statute that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business that involves any item or service payable by the Federal health care programs.
    - AKS looks at a party's intent as an element in determining liability
    - Can include anything of value and take many forms other than cash, ie free rent, hotels, trips, anything deemed to be excessive in value as compensation
    - Includes those who pay, receive or solicit kickbacks
    - Penalties can include jail/prison terms, exclusion from participation in Federal Healthcare Programs, fine of up to $50,000 per kickback plus three times the amount of remuneration (treble damages)
    - **Example:** A medical office gives gift cards to providers or hospital and home-health case management employees who refers patients to their office.

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Compliance Laws Continued

- **False Claims Act (FCA)**
  - The civil FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the federal government. “Knowing” and “knowingly” mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. A person can violate the FCA even if they have no specific intent to defraud.
    - **Example:** A physician knowingly bills for patient services that were not performed or rendered.
    - Penalties are minimum $5,000 - $10,000 plus treble damages for each violation
- **HIPAA**
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established national standards to ensure covered entities and business associates protect the privacy and security of certain health information under the HIPAA Privacy Rule and the HIPAA Security Rule to protect certain health information that is held or transferred in electronic form. (HITECH ACT)
  - OCR can exact penalties and corrective action plans
  - Penalty framework is a 4 tier structure; penalties can be levied agains covered entities, health plans, clearinghouses, business associates

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Compliance Laws Continued

- Penalty Tiers
  - **Category 1:** $100 minimum fine per violation, $50,000 maximum fine
    - Unaware of violation and would not have known violation occurred while exercising reasonable due diligence
  - **Category 2:** $1,000 minimum fine per violation, $50,000 maximum fine
    - Knew or should have known of violation by exercising reasonable due diligence
  - **Category 3:** $10,000 minimum fine per violation, $50,000 maximum fine
    - Willful neglect of rules, violation corrected within 30 days of discovery
  - **Category 4:** $50,000 minimum fine per violation
    - Willful neglect, no effort to correct violation within 30 days of discovery

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RELEVANT CASE LAW

- **Tuomey Health System – South Carolina**, $237 Million settlement for violation of $39 million in false claims April, 2010
  - The premier Stark violation case involving agreements with physicians
    - Required physicians to perform outpatient services at Tuomey facilities under 10 year contracts with two year non-compete clauses
    - Tuomey did the billing and collections
    - Physicians compensated with annual salaries based on net cash collections and productivity bonuses equal to 80% of collections
- **Halifax – Florida ***Placed Medicaid on the Stark Table**
  - Settled $85 Million March 2014
  - Involved agreements with oncologists and neurosurgeons providing base salaries and bonus program equal to 15% of the operating margin and proportional to services performed and exceeded FMV in the 90th percentile
- **Cooper – Jan. 2013, New Jersey**
  - Settled $12.6 Million in claims alleging kickbacks paid to physicians funneled through an advisory board for referrals
  - Paid physicians with high volume practices up to $18,500 to watch 4 marketing lectures per year
- **Intermountain Healthcare, Utah**
  - Self reported in 2009, settled $25 Million April, 2013
  - Failure to review and comply with technical requirements for contracts and leased space
- **White Memorial – California**
  - Settled $14.1 May, 2013 Million for illegal kickbacks to physicians for referrals and for instances exceeding FMV

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RELEVANT CASE LAW

- **1998 HEALTHSOUTH** – falsely reported company earnings by $1.4 billion

- **2000 COLUMBIA HCA**–healthcare fraud, charged or overcharged for services not done or not medically necessary, cost report fraud, fraudulent billing, paying kickbacks to doctors for referrals, and paying kickbacks in connection with the purchase and sale of home health agencies

- **2012 WAKE MED – 2012,** inappropriately billed interventional cardiology services as inpatient that were outpatient

- **2012 NextCare** paid $10 million to settle whistleblower False Claims Act lawsuit alleging company engaged in upcoding and billed Medicare and Medicaid for medically unnecessary procedures.

- **2015** Radiology Billing Company to pay $1.95M to settle claims it violated FCA by fraudulently changing diagnosis codes on Medicare & Medicaid claims in order to get rejected claims paid on behalf of radiologists.

- **2022 Imaging Center in Queens, NY** – posted in RBMA 8/2/2022 – "Imaging center owner/doctor charged with doing $1M-plus in fraudulent claims and services risky-to-patients for unneeded imaging exams that included contrast-enhanced MRIs of the brain, lumbar spine and cervical spine. Charges include grand larceny, healthcare fraud, falsifying business records and violations of a Medicaid anti-kickback statute. The physician allegedly gave gift cards, cash and checks totaling more than $547,000 to three physicians in exchange for patient referrals and allegedly directed his employees to add additional, unordered radiological procedures to orders submitted by referring physicians to increase the amount of money Empire Imaging would receive from Medicaid."
  - Example where it is important to know rules surrounding profee, technical, and global billing test design exceptions.

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RELEVANT CASE LAW- BECKER'S HOSPITAL REVIEW: February 18th, 2022

- **3 Ohio providers to pay $3M** to settle allegations of submitting improper claims to Medicare & Ohio Bureau of Workers' Comp.
- **Florida physician convicted of fraud** for role in billing health insurance companies $110 million in medically unnecessary services
- **Georgia nurse practitioner found guilty of telemedicine fraud,** aggravated identity theft and other charges in multimillion dollar telemedicine scheme.
- **Former Michigan physician accused of 34 counts healthcare fraud, falsifying medical records** and eight counts of making false statements in alleged scheme to bill for surgeries to remove diseased tissue from patients' sinuses despite no presence of diseased tissue.
- **Bon Secours Mercy Health settles $1M false claims case** for allegations it submitted false claims to Medicare.
- **Physicians among 13 charged in $100M healthcare fraud, money laundering and bribery scheme** allegedly orchestrating one of the largest no-fault insurance frauds in history, allegedly bribing emergency dispatch operators, hospital employees and other parties for confidential vehicle accident victim information and fraudulently overbilling auto insurance companies.
- **UC San Diego Health settles false claims case** to pay $2.98 million for allegations it violated the FCA by ordering and submitting referrals for medically unnecessary genetic testing.
  - The genetic testing was performed by CQuentia labs, which allegedly submitted false claims to Medicare for the tests.
- **North Carolina physician faces charges** after allegedly billing Medicare more than $46 million for procedures used for the treatment of chronic sinusitis over a four-year period.

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How to Mitigate & Decrease Risks of Non-Compliance

- Improved clinical documentation
- Routine internal auditing of clinical documentation and coding practices
- Use of technology and systems to assist with automation of coding and claims processing
- Education
  - Coders
  - Providers
  - Healthcare Team
- Attention to detail, routine follow-up & follow-through

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Benefits of Compliant Coding

- Ensures
  - Accurate processing of claims and payment for services
  - Integrity of patient data
  - Transparency
  - Quality and accuracy of patient's record of services, diagnoses and billing
  - Limits legal and regulatory exposure and liability
  - Patient and provider satisfaction

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Q&A

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Thank you!

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