Compliance and "Coding Ethics". This appears to be an obvious statement. Taking a deeper look reveals there is much more to coding ethics than meets the eye.

Historically, coders simply would code what was documented. However with the ever growing critical world of healthcare compliance, what is documented, what is coded, and what is actually treated in a hospitalization – experts can differ.

Some time ago, RMC was asked to perform an audit of the Respiratory Failure DRG 87 (pre-MSDRG’s). While reviewing the charts, the auditor noted there were no ABG’s (Arterial Blood Gases) performed during a large number of the admissions. This finding was rather unusual. It was also discovered on all the charts the providers’ notes clearly documented Respiratory Failure. However clinically, how did they know?

Just because Respiratory Failure is documented (or Sepsis), without any clinical indicators – should it be coded? In the end, this facility did repay a great deal of money for the inappropriate coding/billing of DRG 87. From a compliance perspective, the coders knew it was inappropriate, they tried to get their voices heard – but no one listened.

Recently there has been a lot of activity around the issue of Sepsis. Sepsis historically has been on the radar. From the early years in which physicians rarely documented it (assumptions were made that a patient must have a positive blood culture to be “septic”), to consultants pushing it in the early 90’s, to it being a focus of fraud investigations in the late 90’s. Today there is a great deal of activity with the RAC’s who are also focusing on this problematic DRG.

Coding-wise – Sepsis, and specifically the rules surrounding it, are very challenging. Coders receive mixed messages and even the coding guidelines can leave coders perplexed. The real issue comes down to two questions: 1) Is Sepsis the Principal Diagnosis? And 2) Was it Present on Admission? Those are the two key points in appropriate coding of Sepsis. Coders also have to follow the clinical guidelines as noted in Coding Clinic. Large healthcare corporations have researched and setup wonderful tools for the coders (or Clinical Documentation Improvement “CDI”) to utilize in querying a provider for a possible sepsis case.

The problem now lies in the critical reviews of Sepsis cases. Not only is the appropriate coding being reviewed, but also the clinical side is being addressed as well (“Did the patient really have sepsis?”). Coders are trained to code what is documented. Coders are not clinicians. Coders cannot challenge a provider – nor should they. However, the point of these critical reviews of sepsis cases is well taken. A facility should not be coding/billing for diagnoses in which care was not provided. Specifically – if a patient never really had sepsis the facility shouldn’t be coding/billing Sepsis (similar to the Respiratory Failure example above).

Facilities have done a wonderful job outlining the Sepsis indicators, providing high quality query processes, etc. Facilities also need to have mechanisms in place to avoid (Continued on following page...).
the over usage of query for Sepsis and the overcoding of Sepsis and other high risk diagnoses. Compliance needs to have documentation of expectations as well as communicated these expectations to the providers, clinicians, and coding staff. It is recommended that facilities retain the services of an outside Physician consultant to look at cases that are questionable.

Coders need to know what their role is in coding compliance. Simply just coding what is documented isn’t always correct coding. Coders need to be given the voice to speak up if something doesn’t feel right – and encouraged to do so. Coders need to know directly what they should do, who they should bring it to, and if their concerns aren’t heard, what do they do next to get their concerns addressed. A process (policy) should be in place within the department so the coder would know exactly what steps need to be taken so they do not feel lost.

Trending of DRG’s, coding, and query practices must be monitored, focusing on compliant practices. In a true compliance approach – audits need to address overcoding and undercoding. These issues can be challenging, clinically, politically, etc. RMC recommends facilities address their Audit Plan to assure these steps are included. Additionally it is recommended that facilities revisit their Coding Compliance Plan. Focusing on the query policy and procedures, and also focusing on the “reporting of concerns” directions – assuring the coders have an effective pathway in reporting of concerns.

Dana Brown, RHIA, CHC founded RMC in 1994, with the desire to assist healthcare facilities in obtaining correct reimbursement and minimizing lost revenue through complete and accurate coding, documentation improvement, and education. Prior to founding RMC, Ms. Brown performed DRG Validation, Admission, and Utilization Reviews for the Oregon PRO/QIO. She has extensive management, education and coding experience spanning her 25+ year career in HIM. Ms. Brown’s expertise in Compliance, Inpatient Coding, DRG’s/MSDRG’s, OIG & RAC Targets, Clinical Documentation Improvement, as well as an interest in HCC and Critical Access Hospitals round out her areas of focus at RMC. Ms. Brown’s vision for RMC is to continue to support our clients with exceptional services, delivered by exceptional staff.

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### Usage of Social Security Numbers as Unique Identifiers in Healthcare

Marcia Vaqar, MPH, RHIA, CCS, CCS-P, CCDS

How many times do companies use our Social Security (SSN) as the unique identifier number (UIN) for us? Our employer, financial institution, and even our health care provider, all depend on the number for billing and recording transactions. A study done in 2010 by ID Analytics, Inc. found in a large range of government and company records that it was allowed to have access to; millions of Americans have more than one SSN and millions of SSN shared by more than one person! Out of the 280 million SSN the firm studied across its network of databases:

- More than 20 million people have more than one number associated with their name.
- More than 40 million numbers are associated with more than one person.
- More than 100,000 Americans have 5 or more numbers associated with their name.
- More than 27,000 Social Security numbers are associated with 10 or more people.

The trouble is, experts say, the SSN are no longer unique. At one point in time Margret Amatayakul stated, “Duplication sometimes occurs when patients refuse to provide their Social Security numbers and the hospital or doctors’ office makes up a substitute number that is the same length.” “Not only is the number unauthorized for usage and subject to duplication” stated Peter Swire, a law professor a former White House privacy czar, “but Social Security numbers are used today as identifiers and passwords or personal identification numbers. The overlap of these functions is inherently insecure.”

Social Security numbers (SSN) are bad as far as using them at a technical level because the SSN are unlike the credit card numbers and other ID numbers which have hidden characteristics that can reveal whether a number is valid. With SSN there is not this built-in logic which allows for the added necessary protection.

“Medical identity theft is the fastest growing form of identity theft in America today,” states James Quiggle, director of communication for the Coalition Against Insurance Fraud in Washington, D.C. “With almost 50 million people considered uninsured today, medical identity theft may become a growing problem as more people become desperate enough to turn to crime to find treatments that they cannot otherwise get.”

The American Recovery and Reinvestment Act of 2009 (ARRA) has given an urgency to the need for a national health identifier and because no unique personal identifier has been established, many providers have defaulted to the SSN as an unique identifier but I think we should be asking is this a best practice for hospitals and the providers.

Most facilities using SSN as their unique patient identifiers have security measures in use and allow only those who have a job related need access to the SSN and some restrict it to the last 4 digits of the SSN. These efforts work well within an organization, but once the patient information is to be developed and correlated regionally and nationally and if we are allowed only to use the last four digits of the SSN this would be very inadequate to ensure that correct information was correctly being linked to the correct patient.

Another privacy issue/theft issue is the fact that often times during patient registration staff traditionally will ask for the SSN verbally and even if the staff ask for the card it does not contain a picture or biometric identifiers so there is not any way that the staff would be able to know for sure that the person using the card is the person to whom the card was issued.

A RAND study suggests that creating a unique patient ID number for every person in the United States would help reduce Medical errors, protect patient privacy, increase overall efficiency, and simplify use of electronic health records. Although creating such identification system could cost as much as $11 billion, the effort would likely return even more in benefits to the nation’s health care system, according to researchers from RAND Health. "Establishing a system of unique patient identification numbers would help the nation to enjoy the full benefits of

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Usage of Social Security Numbers as Unique Identifiers in Healthcare” Continued...

electronic medical records and improve the quality of medical care,” said Richard Hillestad, the study's lead author and a senior principal researcher at RAND, a nonprofit research organization. "The alternative is to rely on a system that produces too many errors and puts patients' privacy at risk."

Another RAND study provides additional support in limiting the use of SSN because its report found that “the most likely causes of false-positive errors are data-entry errors and use of an insufficient number of attributes in a statistical search for matches….Larger health record databases, such as those of a national or large regional network, almost certainly require a unique identifier to avoid false-positive errors.”

Barry Hieb, MD who is chief scientist for Global Patient Identifiers, stated, “One of the strongest reasons to adopt a uniform healthcare identifier is its ability to support privacy through the use of anonymous identifiers and anonymized data sets. This promises to enable a new era of patient control of the privacy of their clinical information through the creation of a standardized method to segregate and anonymize information in support of confidentiality and privacy.”

When we look at the dependency on the SSN for connection of information this is not something that can be change overnight. Most likely it will take decades to move through the process of not using SSN in our healthcare systems but healthcare organizations should be taking steps in these directions.

References:


Marcia Vaqar, MPH, RHIA, CCS, CCS-P spent over twenty years as a coding manager, project manager/coordinator of Health Information Management Operations, Inpatient/Outpatient Coder, Health Information Coordinator, and Medical Record Administrative Aide before joining our team. Today Marcia offers her extensive knowledge background to health-care systems in cooperation with RMC, Inc. which includes but is not limited to coding; severity of illness data collection and verification; clinical documentation improvement; and coding management skills.

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or email Kristin Gibson: Kristin@rmcinc.org for details!

November 17th-Physician Topic TBA with Connie Eckenrodt, RHIT, CHC
December 15th-Hospital Topic TBA with Dana Brown, RHIA, CHC
According to the Medicare Claims Processing Manual, observation care is “a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.” In short, the patient is being held under observation to determine if s/he should be admitted, discharged home or sent to another provider. In most cases, reasonable and necessary observation care will not extend beyond 48 hours.

A physician order for admission under observation status is required. The order should explicitly state the status being ordered --- “Admit to observation” --- and the order must be written prior to the initiation of observation services. The order should be signed, dated, and timed.

It is not necessary that the patient be placed in an area designated by the hospital as an “observation unit.” As long as the medical record indicates that the patient was admitted as observation status and the reason for observation care is documented, observation services may be provided in any common area of the hospital such as the emergency department or other hospital unit. Medical necessity for observation services must be justified. In addition to meeting the documentation requirements for history, examination and medical decision making based upon the nature of the patient’s presenting problem(s), the physician documentation should include:

- Notation that the patient was placed in observation status
- The reason the patient was admitted to observation status
- The activities performed to assess, establish and supervise the care
- Notation of periodic reassessments of the patient
- Notation of discharge from observation status

Physicians have several different CPT codes that can be used to bill for observation services. Initial observation care can be billed only by the physician who ordered observation services and is responsible for the patient’s observation care. Medicare instructs that if an observation stay is less than 8 hours on the same calendar day, Initial Observation Care (CPT 99218-99220) only should be billed. A discharge service is not billed in this case.

When a patient receives observation care for at least 8 hours, but less than 24 hours, and is admitted and discharged on the same calendar day, Observation or Inpatient Care Services (Including Admission and Discharge Services) codes 99234-99236 should be billed. Again, a separate discharge service would not be reported in this case. Physician documentation should clearly indicate the time requirements were met for reporting this service.

Observation stays that span two days are billed using the appropriate Initial Observation Care code on the first day and the Observation Discharge code 99217 on the second, or discharge, day.

Effective January 2011 CPT added subsequent observation E/M codes for patients who are held in observation status for more than two calendar days. As with initial observation care, Medicare instructs that only the physician who ordered observation status and is responsible for the patient’s observation care may report Subsequent Observation Care (CPT 99224-99226) for the interim day(s). All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services should bill the appropriate outpatient service codes. Check with other third-party payers for specific guidance regarding use of these new codes, as they may have varying interpretations.

It is important to remember that all related outpatient E/M services provided by the supervising physician in other sites of service (e.g., hospital emergency department, physician’s office, nursing facility) on the same date are considered part of the initial observation care and should be included in the observation care level of service billed.
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