1st Quarter 2021 | Vol. 11 Issue 1

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HCC Coding Audits . . . A Must!

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, AHIMA Approved ICD-10-CM/PCS Trainer

The words "Hierarchical Condition Categories" or HCCs can conquer up some anxiety for HIM Coding, and Clinical Documentation Integrity (CDI) professionals, even for Revenue Cycle and Compliance leadership. Add to that, the word "audit" and we now have uneasiness and even fear. Well, it does not need to be this way. Understanding the HCC basics and the coding audit ins and outs can diminish everyone's anxiety and fears and allow us all to see the many benefits to both.

The Medicare Advantage (MA) payment amounts are adjusted for the relative risk or risk factor associated with the individual enrollee's demographic characteristics: age, sex, institutional status, and eligibility for Medicaid (or welfare) AND disease burden AND disease interaction (via ICD-10-CM coded data). Due to the nature of the MA program, ICD-10-CM codes reported this year (2021), determine resource needs and payment for the next year (2022) and predetermines each year, meaning it is a prospective payment model. In the version 24 of MA there are approximately 9700 ICD-10-CM codes which map to 86 different HCCs, or about 13% of all possible ICD-10-CM codes.

Each HCC has a relative risk factor value or weight (similar to a MS-DRG relative weight). The weight or risk factor numeric figure is used in calculating the payment amount provided to the MA health plan to take care of a particular patient (beneficiary) for the year. There can be multiple HCCs in a given patient encounter and they can be accumulative which really demands coding accuracy. Here are some of the MA HCCs:

HCC	Title/Description	RAF (weight)
HCC 1	HIV AIDS	0.335
HCC 2	Septicemia, Sepsis, SIRS,& Shock	0.352
HCC 6	Opportunistic Infections	0.424
HCC 8	**Metastatic Cancer & Acute Leukemia**	**2.659**
HCC 9	**Lung and Other Severe Cancers**	**1.024**
HCC 10	**Lymphoma and Other Cancers**	**0.675**
HCC 11	**Colorectal, Bladder, & Other Cancers**	**0.307**
HCC 12	**Breast, Prostate & Other Cancers & Tumors**	**0.150**

In this list you see several HCCs for neoplasms, or cancers in bold, these represent **hierarchical** categories. Meaning that if a given patient has HCC 12 (breast cancer), HCC 11 (colon cancer) and HCC 8 (metastatic cancer), the risk adjustment payment is made to the highest risk factor for that group or categories, so of those three HCCs, only HCC 8 would result in risk adjustment reimbursement.

Coding audits have been a part of healthcare for over 50 years but due to reimbursement compliance concerns the importance of complete and accuracy coding is a foremost part of the healthcare revenue cycle. Complete, thorough, and specific clinical documentation is also vital to the accurate capture of ICD-10-CM and HCCs mapping.

There are many benefits to conducting a coding audit which includes but is not limited to the following:

- Identifying and improving clinical documentation AND coding accuracy
- Preventing and correcting regulatory scrutiny and potential compliance risks
- Assisting with education and training (learning from mistakes)
- Improving provider relationships
- Supporting a culture of compliance
- Identifying process and workflow improvements
- Improvement in revenue and reimbursement
- Overall data improvement which supports Risk Adjustment, Pay-For-Performance, Quality and Safety Metrics, Healthcare Surveillance, Disease tracking and Research.

Coding audits are really similar to "projects", with a start and end, and as such can function better if approached that way. This means having certain steps or components in place, starting with the planning and communication, followed by execution, then the reporting and ending with corrective action and next steps; each of these is essential for any HCC coding audit.

Continued...

"HCC Coding Audits" Continued...

When auditing HCCs we need to confirm that the documentation demonstrates and supports that the condition/disease was monitored, evaluated, assessed and/or treated during the face-to-face encounter. Auditing can help to identify any documentation and/or coding gaps so they can be eliminated or improved upon.

The frequency and volume of the audit will need to be determined and having some volume data can help with this process. Having HCC audits at least twice a year, more often if there are patterns or trends in the coding variances is beneficial. Also, having a positive attitude about an HCC audit will help to set the tone for the auditors and your own staff. In addition, keeping the lines of communication open will also aid in having a successful HCC audit experience.

HCC coding audits can be performed internally with your own audit staff/team, externally by a third- party consulting firm/team or both. Often we see the industry best practice is to have "both" internal and externally conducted audits. Some will question why have an external audit? Having a third-party can ensure a non-biased audit, which can often uncover risks and issues that an internal audit does not see. In addition, an external audit often has a broader scope of resources and tools which aides in handling the perpetual and continuous changes in documentation and coding.

Now is the time to get organized and plan your next HCC audit!

References: Report to Congress: Medicare Advantage Risk Adjustment - December 2018 (cms.gov);2022 Medicare Advantage and Part D Advance Notice Part II | CMS; HHS OIG Issues Report Critical of Medicare Advantage Risk Adjustment Practices | Healthcare Law Blog (sheppardhealthlaw.com); Billions in MA OEI-03-17-00471.pdf (hhs.gov); Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns (OEI-03-17-00470; 12/19) (hhs.gov)

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2021 Evaluation and Management Changes

By Cori Bowmer, CPC, CFPC, CPMA, CPPM, CRC

Now that we have all been using the new 2021 evaluation and management guidelines for a couple months now, hopefully the new routine is getting more comfortable. Here are a few reminders of this years' changes and documentation requirements that were effective as of January 1, 2021.

As you may know, the main code set that changed was the "office and other outpatient visits" code set (99201-99215.) The 99201 code has been eliminated of course, and the criteria to select 99202-99215 has changed and the codes are now selected based on medical decision making (MDM) or time. The American Medical Association has put together a great reference grid to select the level of service based on MDM, which you can find at: https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf.

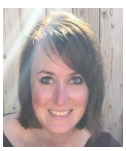
The MDM now consists of the following three categories:

1. the number and complexity of problems addressed
2. the amount and complexity of data ordered, reviewed, or analyzed
3. the risk of complications, morbidity, or mortality.

The grid is similar to the 1995 and 1997 table of risk grids, but there are a few differences, especially in the data column. But there are great notes within the grid to help remind us what the requirements are to meet each category and in turn, each E/M level.

Time may also be used to bill for the 99202-99215 codes; however, the time requirements have changed for this category. Counseling and coordination of care are no longer required to dominate the visit and in fact, the provider's total time spent on the encounter can now count towards the service, including non-face-to-face time before or after the patients appointment. Non-face-to-face time may include any of the following: preparing to see the patient, reviewing/ordering tests, referring and communicating with other healthcare professionals, and documenting clinical information in the health record. The code descriptions have also changed to include time ranges instead of a minimum time, which is an important distinction especially when considering if prolonged services can be billed. The new prolonged service code for non-Medicare patients is 99417 and can be used along with 99205 and 99215 codes when an additional 15 minutes or more is spent beyond the minimum time stated in the time range for the level 5 office visit codes. Medicare uses HCPCS code G2212 for prolonged services instead which requires an additional 15 minutes or more beyond the maximum time listed for the level 5 office visit codes.

Medical decision making or time can be used to choose the level of service in this category, whatever is most advantageous to the provider based on documentation of course. And even though the history and exam elements are no longer used for the office visit and other outpatient categories any longer, they would still be expected documentation as medically appropriate to support medical necessity of the visit. After all, CMS continues to view medical necessity as the overarching criteria in determining the level of service and MDM and medical necessity are not the same thing.



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Coding COVID-19 in 2021

By Mary Chelucci, RHIA, CCS & Jennifer Jones, RHIT, CCS, CCDS

We have all been keeping up with COVID-19 and the code and guideline changes that have evolved since original coding advice came out in February of 2020.

The advent of code U07.1 was a "game changer". This code was created and made effective after April 1, 2020. The coding directive in this code states: **Use additional code to identify pneumonia or other manifestations.**

What is a manifestation vs. a sign/symptom? Per JAMA (Journal of the American Medical Association):

"A *symptom* is a manifestation of disease apparent to the patient himself, while a *sign* is a manifestation of disease that the physician perceives. The sign is objective evidence of disease, a symptom, subjective. Symptoms represent the complaints of the patient, and if severe, they drive him to the doctor's office. If not severe, they may come to light only after suitable questions. The patient perceives, for example, subjective pains and discomforts [Doctor, I have a bad headache], or disturbances of function [Doctor, I can't move my arm the way I used to], or some simple appearance [Doctor, I have had this rash for the past ten days and I'm worried about it]."

According to NCIB (National Center for Biotechnology Information, U.S. National Library of Medicine):

"Regarding SARS-CoV-2, in general, these findings are nonspecific, such as dyspnea, fever, cough, and headache. The severity of the infection may vary from asymptomatic patients to severe cases of pneumonia that can lead to death. Initially, the disease was characterized by the triad fever, cough, and shortness of breath. The US Center for Disease Control and Prevention (CDC) subsequently added chills, muscle pain, headache, sore throat, and loss of taste or smell to this list (neurological manifestations)."

The JAMA and NCIB (reference links below) are using the terms "manifestations" and "symptoms" interchangeably. In the absence of specific diagnoses that are manifestations of COVID-19 (such as pneumonia, respiratory failure, multisystem inflammatory syndrome, etc.), the manifestation would be the symptom, such as fever or shortness of breath.

Manifestations in the COVID-19 guidelines say they are "examples" (pneumonia, acute bronchitis, acute respiratory infection, etc.), so not a totally inclusive list. The Coding Guidelines for COVID-19 state that if a patient is given the diagnosis of COVID-19, code also the *manifestations* of COVID-19. Again, in the absence of a more specific manifestation like pneumonia, respiratory failure, ARDs, multisystem inflammatory syndrome, etc., the symptom would be considered the manifestation. There is also a Coding Guideline regarding the use of symptoms codes, which says, "Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider".

It is important to follow the coding directive for U07.1 and add the manifestations that are documented by the provider.
In summary, in the absence of a definitive diagnosis such as pneumonia or bronchitis, the use of a sign or symptom code would be used as the manifestation.

REFERENCES:

Coding Guideline I.C.1.g.c. (COVID Manifestations); Coding Guideline 1.B.4 (Symptoms)
https://www.codingclinicadvisor.com/sites/default/files/Frequently%20Asked%20Questions%20Regarding%20COVID-19_v14C_Secure_0.pdf (FAQ #24, #25, #26); https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7689634/:; https://jamanetwork.com/journals/jama/article-abstract/341611:

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The OIG Workplan and Building Your Own Coding Compliance Program

By Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, AHIMA Approved ICD-10-CM/PCS Trainer

Each year the Office of Inspector General (OIG) publishes their annual work plan for healthcare, which is a highly anticipated publication. The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year. In addition, the OIG updates their workplan on a monthly basis, so their areas of focus can change or be revised, so it requires us to confirm that we check the OIG website each month. In fact, in the month of January 2021 there were several COVID related items additions made to the workplan. The workplan does cover many healthcare areas of the Health and Human Services (HHS) department, and the Centers for Medicare and Medicare Services (CMS). The workplan can be viewed at: Work Plan | Office of Inspector General | U.S. Department of Health and Human Services (hhs.gov)

This workplan document is extremely valuable for us in Health Information Management (HIM) and Coding to review and learn from. HIM Coding professionals and leaders building a coding compliance program and/or an annual plan should take into consideration the OIG areas that are identified as risks and/or potential risks to help with building your own coding compliance program/plan. Keep in mind that this does not have to be done alone, consider having a staff representative from Coding, Revenue Cycle, Compliance and even Clinical Documentation Integrity (CDI) leadership participate in the process, ask your workplace peers and colleagues to participate. Let us now discuss some steps to take when building your Coding Compliance Program/Plan.

1. A vital step to take is to conduct a close review of the OIG workplan document and through this review process highlight those areas or even specific language that is related to HIM, coding, or even related to payment errors in general, i.e., documentation issues.
    a. The review should include identifying the healthcare settings or areas that you work in and that effect or impact your organization and/or department. If you work or represent an acute care hospital ONLY, then you have a narrower focus, compared to a healthcare corporation that may provide services in many Hospitals, Rehab, Clinic, and provides SNF ser vices, then you will be looking more broadly at the workplan.
2. As you continue to use the OIG work plan, develop/create a list, even use a spreadsheet (Excel) to log those items or areas that you've high-lighted from the work plan. List them by healthcare setting: i.e., Hospital Inpatient, Hospital OP, Physician, SNF, etc. Using the spreadsheet being to insert columns and rows that display the risks and settings, as well as a level of risk (discussed later).
3. Next, you will want to look over prior OIG work plans (last 3-4 years) and compare it to the current year (prior excel spreadsheet (grid) listing of the risk areas). Risk items do carry over and move into different components of the OIG work over-time.
4. Review other regulatory compliance related published reports, such as the CERT report, PEPPER, and RAC work plans and scope. Determine if there is/was any correlation to the OIG workplan targets. Using the spread sheet have columns to indicate OIG, CERT, PEPPER, RAC, RADV, and Other, in order to capture a full scope of regulatory scrutiny. Check (X) the particular column to indicate where the published target or risk area(s) came from.
5. Now look over your coding audit error type from the last year or last few audits as these should be incorporated that into your spreadsheet within a column. Insert a column for "internal audits" and "external audits" to capture this information.
6. Your work plan spreadsheet will need to rank or rate the level of "risk" for the area(s) that were identified abd hi-lighted. You might want to consider including a column to indicate if the risk area has been on a prior audit plan/schedule, and a column for "future audit". are several ways to do this, but simply, do a 1 to 10 scoring, 10 being the most risk and needs immediate attention (within 30-40 days). Details on scoring or ranking the risk might include financial impact, public disgrace/reputation, volume/frequency, significant operational change, etc. Discuss the risks and the appropriate level with your team of peers and colleagues.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	SETTING	Type of Risk	OIG	Risk Level	CERT	Risk Level	RAC	Risk Level	RADV	Risk Level	PEPPER	Risk Level	Other	Risk Level	Int Audit	Risk Level	Ext Audit	Risk Level
2	HOSP - IP	Dx Malnutr.	X	7														
3	HOSP -IP	COVID DX	X	9														
4	HOSP-IP MSDRG	MCC/CC									X	8						
5	HOSP - ED	Dx HCC							8						X	7		
6	HOSP - IP PACT	Disch Dispos	X	6													X	7
7																		

7. Next, you will want to take the time to discuss the list within your department and with colleagues, comparing the risk items/areas to our own healthcare operations, and settings. Again, take a look at the OIG reports that have been regularly published, as these are often the results of the OIG work and are red flags (i.e., Malnutrition diagnosis, Post-Acute Care Transfers), which may not be in the actual 2021 work plan, but come from a prior work plan 3-4 years ago. When ranking the risk level, you will want a threshold that would require auditing and a level that will require education OR both.
8. For your coding compliance program/plan, you will want to discuss and determine the resources needed. If the area of risk can be audited and educated on with internal staff alone or do we need to have external help. Is there a resource tool or handbook that needs to be purchased. I recommend and have found that having both internal and external help is the best model. This may or may not impact your budget and available funding, so work closely with your compliance and revenue cycle leadership.

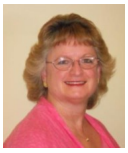
The OIG workplan for 2021 has indicated that telehealth, the two-midnight rule, Lab billing for COVID, and the inpatient COVID 20% add on payment (test positive) are all risk areas that OIG will be focusing on. One final thought is to reach out to other HIM colleagues and peers

Continued...

"The OIG Workplan" Continued...

outside your organization or workplan and share, as well as gathering information about their plans and processes. Time is ticking, so get working on building your program/plan now.

References: Work Plan | Office of Inspector General | U.S. Department of Health and Human Services (hhs.gov); DHHS Fiscal Year 2021 Justification of Estimates



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Healthcare Organizations: What can get you into [costly] hot water?

By Chris Apgar, CISSP, C|CISO

For healthcare organizations and the businesses that support them, regulation and legislation too often turn into lawsuits and settlements. What's happening to get you into trouble in the first place? How can you avoid the serious costs they bring – to the bottom line and to reputation? Here's what we often see in a "from the trenches" perspective.

Policies & Procedures Misalignment

In other words, either you didn't do what you said you were going to do, or you have serious gaps in what should be written down and followed. Here's the thing about policies and procedures, they have to be accurate, yes, but they also should say what you will do, not just what you can do.

Do you say you're going to test and check your firewall every 30 days? Better have that proof ready to show that you did it. Do you state that your mobile device use includes information security standards for mobile device hardening to protect PHI? Prove the steps you take – encryption, remote wipe capabilities, device tracking, etc.

If you don't or can't produce proof, and there's a PHI breach, any legal action will include turning over privacy and security policies. You want to be able to do that with confidence.

Here are our Policy & Procedure Quick Tips, in a short video-format. Feel free to share. https://youtu.be/mJdEEvCuoW8

Breach Incident, No Security Incident Response Plan (IRP)

Naturally, if you do experience a PHI breach, or any type of breach incident, you want to be able to take action. The thing that stinks is that even a not-so-bad breach can bring the wolf to the door, lawsuit-wise. At one point, if there was no proof of harm (e.g., identify theft), then there was a chance the courts may show leniency. That happens far less often these days. Especially when you can't demonstrate that your security Incident Response Plan is reliable (or if you don't have one in place).

Think about what the courts will want to see - or better yet, what a security risk analysis would reveal about your security IRP. Can you show that everyone knows what they're doing and how they need to respond to a breach? If you're not sure, talk to us about your security Incident Response Plan – we have a short motion graphic on that here https://youtu.be/oJ7UlM5Q2lQ

Obviously, there's no way to 100% guarantee you'll never have a breach. What you can guarantee is that you have the right safeguards in place, that there's a provably in-practice set of policies and procedures, and that when the breach did happen you had a super-viable security IRP to make things right as quickly as possible.

Chris Apgar*, founder of Apgar & Associates is a Certified Information systems Security Professional (CISSP). He is one of the country's foremost experts and spokespersons on healthcare privacy, security, regulatory arriafs, state and federal compliance and secure and efficient electronic health information exchange. Chris has more than 19 years of experience in regulatory compliance and is a leader of regional and national privacy, security and health information exchange forums. As a member of Workgroup for Electronic Data Interchange, and serving on the Board of Directors since 2006, Chris is an honest, reliable, trustworthy expert in the field of privacy and security.*

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