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RMC COMPLIANCE CONNECTIONS

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2022 OIG Work Plan: Balancing a focus on overall compliance and the public health emergency

By Aurae Beidler, MHA, RHIA, CHC, CHPS

What another crazy year, huh?! In 2021, the OIG continued to publish its work plan with monthly updates including OIG audits and evaluations for the fiscal year and beyond. Although the COVID-19 pandemic continues on, healthcare operations and government oversight entities such as the OIG continue their work. As of the end of November 2021, the OIG had published 12 new issues during the month of November.

Yet emergency waivers and flexibilities have kept our eyes on the immediate public health emergencies. When the waivers finally end, what will the world of healthcare compliance enforcement look like?

It's important to not let our compliance efforts lax as the OIG continues to publish new items and revise many that have been planned for several years. We are tasked with monitoring our operations to guarantee an effective compliance program. One key method is to monitor potential risk areas published by the OIG. Paying attention to what the OIG for Health and Human Services (HHS) plans to audit and monitor during the upcoming year should be a one of the key drivers in developing your own annual audit plan.

Although the OIG no longer publishes out an annual work plan, you can still prepare your organization's compliance work plan as was done in the past. However, this year, as the pandemic continues to affect our operations and even our compliance work plan effectiveness you may approach it a bit differently. One approach is to go to the OIG work plan and look at the items that have been added since the public health emergency began. You can then sort through them for the applicable items related to your organization's services. Although the plan is specific to what the OIG plans to audit in respect to HHS programs, it provides a plan of the audits that organizations may experience as well. The OIG items covers Medicare, Medicaid, FDA, Substance Abuse/Mental Health, Public Health, Indian Health Services and Other.

After reviewing the OIG items, you may consider some questions related to your 2022 compliance work plan including:

- Has the public health emergency (PHE) resulted in items to add to your plan?
- Due to the PHE, will you be narrowing the focus of you plan? Or expanding your plan?
- Were there items you deferred during 2021?

Some of the most notable recent and active OIG work plan items include:

Telehealth Services

- In October 2020, CMS announced the plan to begin auditing Medicare Telehealth Services. The item was revised and expected to occur in 2022. CMS has implemented a number of waivers and flexibilities that allowed Medicare beneficiaries to access telehealth services. Medicare Part B and C data will be reviewed for program integrity risks associated with telehealth services during the pandemic. OIG will analyze provider billing patterns. Although there isn't a lot of detail, you should continue to watch for updates and review once the initial audit is published.
- OIG will also be reviewing Medicaid Telehealth for oversight of state agencies and waivers that occurred during the PHE. This item was also revised from 2020 and expected in 2022.
- OIG will also focus on selected States use of telehealth in behavioral health services. It will analyze how these States and managed care organizations (MCOs) use telehealth to provide behavioral healthcare. It will also review selected States' monitoring and oversight of MCOs' behavioral health services provided via telehealth.

Pain Audits

- OIG has revised its focus on several pain management audits including facet joint injections, facet join denervation sessions, lumbar epidural injections and trigger point injections under Medicare Part B. Providers should review their services and documentation to ensure compliance with federal requirements. In 2022, OIG will issue a report on provider compliance.

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OIG Workplan continued...

Two-Midnight Rule for Inpatient Admissions

- OIG announced a revised plan to begin auditing short stay claims in 2022 related to the implementation of the Two-Midnight Rule in Fiscal Year 2014. Under this rule, it is generally considered inappropriate to receive payment for stays not expected to span at least two midnights. OIG will begin auditing short stay claims and recommending overpayment collections.

Other key items to look at for 2022 include payments for clinical diagnostic laboratory tests, waiving or reducing co-payments under telehealth policy, infection control items related to guidance in some areas, Medicaid provider enrollment, COVID inpatient discharges, cybersecurity review of HHS, review of CARES Act, Provider Relief Funds, emergency preparedness and other long standing OIG audit areas.

No matter when an organization reviews the OIG Work Plan, this resource is important in creating an annual audit plan and educating leadership on ongoing OIG activities.

Aurae Beidler, MHA, RHIA, CHC, CHPS *has worked in the health care industry since 2002, for health systems and outpatient clinics including behavioral and dental health, with an emphasis in compliance operations and program implementation, training, auditing and privacy of health records. Aurae has experience with coding and billing issues, risk assessments, regulatory interpretations, internal investigations, responding to external audits and investigations, writing appeals for denied claims, policy and procedure creation, provider education and training, risk management and provider malpractice insurance and determining clinical billing risk by performing audits and investigations. She has overseen and assisted with the implementation of a privacy and security program for outpatient clinics and developed an institutional compliance program, published several articles in Compliance Today and the Journal of AHIMA, and serves on AHIMA's Privacy and Security Practice Council.*

Coding Uncertain Diagnosis in the Pro Fee Setting

By Susan Morton, CPC, CPC-I, CEMC, CGSC, COBGC

As coders we are often torn when it comes to coding a diagnosis when the provider's documentation isn't perfectly clear. It may sound elementary, but we must go back to the Official Coding Guidelines and stick to those to ensure we are reporting the correct diagnosis based on the documentation. Per the Official Coding Guidelines, Section IV.H, "Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," "comparable with," "consistent with," or "working diagnosis" or other similar terms indicating uncertainty."

It is not always possible for a provider to document a definitive diagnosis at the end of the encounter. Oftentimes, the provider must run more tests in order to come to a certain diagnosis. However, in the meantime, the provider may start treatment, with the thought that the diagnosis is very probable without the definitive testing confirming the condition.

One such example that is seen frequently is symptoms of a UTI where the provider documents "probably UTI" but then starts the patient on an antibiotic before the testing (typically urinalysis or culture). In this example, even though the provider starts the patient on a medication to treat a UTI, as coders we can't report the UTI diagnosis, since the provider's documentation doesn't definitively state the diagnosis as a UTI. We must revert to reporting the signs/symptoms that the patient presented with, which include but not limited to: burning with urination, frequency in urination, blood in urine, pain or pressure in the lower back or other such symptoms.

The OCG IV.H goes on to state that coders should "code the condition(s) to the highest degree of certainty for that encounter/visit such as signs, symptoms, abnormal test results, or other reason for the visit." Coders should keep in mind to report the information documented to the highest degree of certainty based on the documentation for the encounter and keep in mind that is it acceptable to report any abnormal test results when those reports are available at the conclusion of the encounter.

Coders also see providers document history of a condition but also provide a prescription for that condition. For example, a provider may document "History of gout, patient to continue Allopurinol." Although, the patient is being treated with a medication for gout, the provider's documentation must specifically state the patient still has the condition. In this instance, as a coder, we should query the provider to clarify for clarification. If the coder doesn't have an option to query the provider, a history-of code is the only option for coding this encounter, because that is the information documented by the provider.

Coders should take any opportunity provided to educate providers regarding the diagnosis documentation. Providers should be reminded to always document to the highest degree of certainty in order to ensure the coding staff is able to report the best code to the patient's insurance carrier. While the diagnosis doesn't necessarily drive payment in the Pro Fee setting, it is imperative that we as coders report the most accurate diagnosis available and supported by the documentation.

Susan Morton, CPC, CPC-I, CEMC, CGSC, COBGC *is a Manager of Physician Coding Services at RMC. Susan has been working in the medical field since 1996, within physician offices. In addition being a Certified Professional Coder, she also holds specialty certifications in Evaluation and Management, General Surgery and OB/GYN and is a certified AAPC instructor. She has experience in professional fee coding, provider auditing (retrospective and prospective) and coder/provider education. Her experience ranges from small to large multi-specialty groups and large teaching hospitals. Susan also has experience coding Ophthalmology (to include Optho-plastics), Infusions for Chemotherapy, General Surgery (to include bariatric surgery), and Dialysis.*

The OIG Focus on Clinical Coding

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

The last 12-18 months has brought the healthcare industry many audit reports from the Office of Inspective General (OIG). These reports are always an important part of every Compliance Program and the related audit and educational activities. Certainly, for Health Information Management (HIM), the OIG audit reports can provide a lens into issues, vulnerabilities, and noncompliance with clinical coding. Now before I go any further let's all acknowledge that we have to consider the clinical " documentation" that may be the direct source of clinical coding issues. As we are about to end our second year with a Public Health Emergency (PME) due to the COVID-19 pandemic, it's good to look back and reflect upon the OIG focus on Clinical Coding.

The mission of the Office of Inspector General (OIG), as mandated and amended by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections. The following are the areas in which the OIG work is conducted:

- Office of Audit Services
- Office of Evaluation and Inspections
- Office of Investigations
- Office of Counsel to the Inspector General

Another key component to the above mission is the OIG Annual Work Plan. The "Work Plan," which is regularly updated with topics or focused issues is a major resource with Compliance, Revenue Cycle and HIM. Go to the OIG HHS website for more information: https://oig.hhs.gov/

We saw that CPT™ coding and documentation were being focused on within the OIG work titled, "***Use of Medicare Telehealth Services During the COVID-19 Pandemic"***; this area of focus was announced in July of 2020. With the increased use of "Telehealth" it's important to have ongoing auditing and monitoring of this service line which could be at the physician office or in the hospital outpatient setting.

The OIG report titled: ***"Inadequate Edits and Oversight Caused Medicare To Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services"*** was published 8-05-2020, number A-04-18-04067 . Although not specific to ICD-10-CM/PCS coding, the acute care hospital coding professional often selects and/or assigns the discharge status code (discharge disposition) so this is a subject to audit and educate on.

In June 2020, the OIG announced they will audit the ***"CARES Act Provider Relief Funds—Distribution of $50 Billion to Health Care Providers".*** In September, the OIG audit Medicare payments made to hospitals for COVID-19 discharges that qualified for a 20 percent add-on payment under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. This OIG work is titled, ***"Audit of Medicare Payments for Inpatient Discharges Billed by Hospitals for Beneficiaries Diagnosed With COVID-19"***. This OIG issue does cite ICD-10-CM code(s) that every HIM coding professional should read about. The CMS MLN SE20015 was updated on September 11, 2020, New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act, this MLN can be found at: SE20015 (cms.gov)

During 2021, the regular RMC blogs have provided information on many of the OIG audits and activities during the year. For Clinical Coding Professionals, these OIG Audit Reports serve as "red flags" of noncompliance and provide direction on areas of weakness and those prone for errors. The February OIG report titled, ***"Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny"*** was released. This report has brought attention to MS-DRGs and the documentation and clinical coding. MS-DRG 871 Septicemia or Severe Sepsis without MV 96 hours with MCC", was discussed as a potential ICD-10-CM coding problem, thus auditing very closely this particular MS-DRG and the supporting clinical documentation is vital to conduct.

Early May 2021 the OIG report titled, ***"Medicare Hospital Provider Compliance Audit: Virtua Our Lady of Lourdes Hospital"***, was released and targeted a variety of settings and issues:

- IRF claims
- inpatient claims billed with Comprehensive Error Rate Testing (CERT) high-error rate DRG codes
- inpatient claims billed with high-severity- level DRG codes
- inpatient mechanical ventilation claims
- inpatient claims paid in excess of charges
- outpatient claims paid in excess of $25,000
- outpatient claims paid in excess of charges
- outpatient bypass modifier claims
- outpatient surgeries billed with units greater than one
- outpatient skilled nursing facility (SNF) consolidated billing.

In September, the OIG released a report titled: ***"Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments"*** (OEI-03-17-00474) which came from the OIG department of "Evaluations and Inspections". This particular OIG report can be accessed via the following link: https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf. In an October 2021 OIG audit release, came the report titled, ***"Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Coventry Health Care of Missouri, Inc. Submitted to CMS"***. In this particular OIG Audit focused upon Hierarchical Condition Categories (HCCs) from ICD-10-CM codes in the following categories:

- Acute stroke
- Acute heart attack

Continued...

OIG Focus on Clinical Coding continued...

- Vascular claudication
- Major depressive disorder

Potential misdiagnosis (Defined by the OIG as when a patient received multiple diagnoses for a condition but received only one—possibly mis-keyed—diagnosis for an unrelated condition)

Whether it's a lack of clinical documentation, incorrect CPT codes, ICD-10-CM/PCS codes, or a combination of documentation and coding, there is lots that the OIG is looking at in the clinical coding arena. Please note that I've not included all of the OIG audit reports that were or maybe were related to clinical coding, but you get the message loud and strong for the above.

So, yes, these OIG audit reports are extremely valuable and can aide in focusing on the clinical coding areas as well as documentation with vulnerabilities. Discuss the OIG reports with your Coding staff, Auditing team, Compliance and Revenue Cycle leadership. Coding education should be continuously and not just twice a year associated with the code updates. It takes more than education twice a year to increase ones knowledge about clinical coding. Healthcare regulatory scrutiny is clear and present; thus, the time is now to be proactive, so drive and strive for accuracy. Ensure that errors are corrected and that rebilling or refunding is completed as well. Best of luck with your auditing and education and let's make it a point to be attentive to the 2022 OIG healthcare audit reports!

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer *is a nationally known author, educator, speaker, and advocate for the HIM Coding professional with over 40 years of experience in the industry. Ms. Bryant is also the Past-President of the California Health Information Association and has served on several AHIMA committee's and Task forces, relating to the topics of physician querying, coding ethics and coding compliance. She served on the ACDIS board and CDI certification committee in the past as well.*

Walking the Tightrope in HCC Coding

By Dana Brown, MBA, RHIA, CHC, CCDS, CRC

The "coding" for HCCs (Hierarchical Condition Categories) is not for the faint of heart. At RMC, we have been in the risk adjustment HCC arena (auditing, coding and educating) since 2006. As an outsider or non-coder, looking in, it would appear to be so simple, BUT, It is not simple or easy. No one should do HCC coding without extensive documentation and coding training as well as HCC code capture training – and preferably this person should be a certified coding professional. Nurses, Physicians, and administrative personnel do not have this level of education and training, so they should not be leaned on to act as an expert in HCC code capture compliance, unless they also hold a coding certification

HCC's are based on patient specific demographics and diagnosis code capture, emphasis on the "diagnosis code capture." Diagnosis code capture is based on nationally recognized Official Guidelines for Coding and Reporting. . These are published every year and they are an awesome resource for accurate and compliant coding. Also, there is the American Hospital Association (AHA) Coding Clinic for ICD-10-CM. This AHA quarterly publication dates back to 1983 and requires a paid subscription but is also essential for accurate and complaint coding. The Guidelines and Coding Clinic go hand in hand and every coding professional should have access to and utilize these on a regular basis. These two resources provide specific coding guidance for inpatient facility coding, outpatient facility coding, and professional fee coding. Coding in these various settings can be quite different and an experienced HCC coding professional or auditor must be very familiar with these directives going back nearly 40 years.

Even though the Official Guidelines and the Coding Clinic are both amazing resources and invaluable really for compliance, there are still many grey areas in coding that can be up for interpretation. If a coding professional has a question, that is not answered in these resources, they must submit an online question to Coding Clinic for guidance This is especially important if it affects the capture or non-capture of a particular diagnosis code (which drives an HCC, which drives the risk adjustment revenue).

There are some healthcare practices and organizations that have been in the news regarding their approach to HCC capture. Two areas are of concern: 1) Documentation and 2) Coding Accuracy. "Documentation" means what specifically is written or documented in the medical record from the encounter of care or hospitalization. Only documentation by the following medical professionals is acceptable: MD, DO, PA, NP, and CRNA (there are some exceptions). "Coding Accuracy" means how the coding that is submitted and billed (which in turn is the HCC) is supported within the record and assigned correctly (according to Official Guidelines).

In regards to documentation, the issues in the news are varied, however, one issue in the news is that some organizations are leading and incentivizing providers to over-document and/or adding diagnoses. Also, EMR's that are only giving options of diagnoses that are HCC's (when the most common diagnosis is not an HCC), has occurred, such as directing the provider to the diagnosis associated with HCC payment. Another issue is using EMR technology in a creative way in which diagnoses are pulled from one document source and embedded in another such as a clinic note – which then makes it appear that the provider is approving it as a diagnosis that was assessed, treated and/or managed and should be code-able.

Coding accuracy – to perform coding accurately, as stated above, you must utilize a highly skilled and trained HCC coding /auditor professional that is a trusted member of the Team. This individual will play a pivotal role in assuring overall compliance, an accurate interpretation of coding guidelines, documentation, and documentation practices. Organizations must abide by the Official Guidelines, and not assume that skirting the issues, or interpreting a gray documentation or coding area to the benefit of the organization, is compliant.

Compliance involves integrity and assurance of accuracy in submission of diagnostic codes in the risk adjustment models. This is the tightrope – ensuring the there is a balance between ethical and compliant submission of coded data is foremost. Yet striving to capture all the diagnosis codes accurately that reflect the true severity and clinical picture of the patient, based on documentation is also a primary goal and this goal if obtained will result in appropriate and accurate reimbursement.

Dana Brown, MBA RHIA, CHC, CCDS, CRC, President *- Ms. Brown 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 30+years 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.*

Those Pesky Z Codes: The When, How and Why

By Stacy Hartstine, RHIT, CCS

Chapter 21 in ICD-10-CM contains our "Z" codes. Z codes (other reasons for healthcare encounters) may be assigned as appropriate to further explain the reasons for presenting for healthcare services, including transfers between healthcare facilities, or provide additional information relevant to a patient encounter. The ICD-10-CM Official Guidelines for Coding and Reporting identify which codes maybe assigned as principal or first-listed diagnosis only, secondary diagnosis only, or principal/first-listed or secondary (depending on the circumstances). Assign as many codes as necessary to fully explain each healthcare encounter. Since patient history information may be very limited, use any available documentation to assign the appropriate external cause of morbidity and Z codes.

Z codes are designated as the principal /first listed diagnosis in specific situations such as:

- To indicate that a person with a resolving disease, injury or chronic condition is being seen for specific aftercare, such as the removal of internal fixation devices. One example would be an encounter to remove orthopedic pins.
- To indicate that a person is seen for the sole purpose of special therapy, such as chemotherapy, immunotherapy and radiation therapy.
- To indicate that a person not currently ill is encountering the health service for a specific reason, such as to act as an organ donor, encounter for medical observation for suspected diseases and conditions ruled out, administrative examinations (pre-employment exam, recruitment to armed forces), plastic and reconstructive surgery following medical procedures or healed injury (breast reconstruction following mastectomy).
- To indicate the birth status of newborns

There are several categories of "Z" codes found in Chapter 21 and they include encounters for Contact/Exposure to communicable diseases, Inoculations and vaccinations, statuses, personal and family history, Surveillance/Screening, aftercare, follow-up, observation, organ donor, counseling, encounters for obstetric and reproductive services, newborns and infants, and routine/administrative exams. Individual facilities may have internal policies that differ on capturing of certain Z codes so make sure you review your facility's policies. Here are a few tips for when to use certain categories of Z codes:

- Observation (Z03-Z05) The observation codes are generally used as a principal/first-listed diagnosis only but may be assigned as a secondary diagnosis code when the patient is being observed for a condition that is ruled out and is unrelated to the principal/first-listed diagnosis.
- Follow codes (Z08-Z09) These codes indicated for continued surveillance (treatment has been completed and disease, condition, or injury no longer exists.
- Screening/Surveillance codes (Z11-Z13) are used for Testing in healthy individuals so early detection and treatment can be provided and the patient has no sign or symptoms of the disease/condition.
- Aftercare codes (Z47-Z48) are used for patients receiving continued care in the healing phase or for the long-term consequences of a disease. Reminder: Do not use these codes with the injury codes, instead code to the specific injury with the 7th character for subsequent encounter.
- Counseling Z codes are found throughout chapter 21 and are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems

If you would like more detailed information on the application of Z codes and related Official Coding Guidelines, please join us for RMC's December audioconference; *Those Pesky Z Codes: The When, How, and Why.*

Stacy Hartstine, RHIT, CCS *is the Director of Coding Services at RMC. Stacy started in healthcare in 1994, working in various clinics and hospital settings. Holding positions as office manager, coder, Director of Health Information and Privacy Officer. In 2006 Stacy joined RMC as a Manager over the Texas Region. Stacy has proven herself to be an accomplished coder, auditor, manager, and now Director of Coding Services at RMC. In this position, Stacy is ultimately responsible for the overall success of the Hospital Division at RMC. Assuring exceptional client satisfaction with excellent services and exceptional customer service. Additionally, RMC staff engagement is a top priority.*