Let Ethics Drive Compliance
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This material is designed to offer basic information
for coding and billing and is presented based on
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education guide only.

Outline
1. Legal Issues Coders Need to Know and Comply With
2. Ethical Issues in Coding and Billing
3. Examples of Unethical Practices
4. Practical and Professional Ways to Handle Ethical Dilemmas

1:
Legal Issues Coders Need to Know and Comply With

HIPAA & HITECH
False Claims Act (FCA)
Anti-Kickback Statute (AKS)
Stark Law

OIG Strategic Plan 2014 - 2018
U.S. Department of Health and Human Services
Office of Inspector General (OIG):

Four Goals
1. Fight Fraud, Waste, and Abuse
2. Promote Quality, Safety, and Value
3. Secure the Future
4. Advance Excellence and Innovation

OIG HEAT
“Deliberate Ignorance”

Navigating the Fraud and Abuse Laws

Source: Health Care Fraud Prevention and Enforcement Action Team (HEAT)
http://oig.hhs.gov/heat/
CMS Medicare: Fraud

- "making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist"
  - Knowingly billing for services that were not furnished and/or supplies not provided, including billing Medicare for appointments that the patient failed to keep; and
  - Knowingly altering claims forms and/or receipts to receive a higher payment amount.

- Both fraud and abuse can expose providers to criminal and civil liability

Source: CMS Medicare Fraud & Abuse: Prevention, Detection, and Reporting

CMS Medicare: Abuse

- "practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program"
  - Misusing codes on a claim,
  - Charging excessively for services or supplies, and
  - Billing for services that were not medically necessary.

- Laws to address Fraud & Abuse
  - False Claims Act, Anti-Kickback Statute, Physician Self Referral Law (Stark), Social Security Act, and U.S. Criminal Code

Source: CMS Medicare Fraud & Abuse: Prevention, Detection, and Reporting

HIPAA & HITECH

- Health Insurance Portability and Accountability Act (HIPAA) governs the transmission of medical records containing medical information
  - Regulates the disclosure of patient protected health information (PHI)

- The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 increased regulations and requirements for preventing and reporting PHI breaches

False Claims Act (FCA)

- Enacted during the American Civil War, also known as the “Lincoln Act”
  - Fines ranging from $5,500 to $11,000 and treble damages for knowingly presenting a false or fraudulent claim to the government

- Revised over the years to strengthen the penalties
  - Modified in 2009: 60 days to repay an overpayment (known or should have known)

Stark Law & Anti-Kickback Statute (AKS)

- AKS prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or generate federal healthcare business

- Stark Law (Physician Self Referral Law) prohibits a physician from referring Medicare patients for designated health services (DHS) to an entity with which the physician (or immediate family member) has a financial relationship
  - "Strict liability" law

What Can Happen?

- Restitution – heavy fines
- Penalties are predetermined
- Probation
- Corporate Integrity Agreements (CIA)
DOJ FCA Settlements

DOJ 2/11/13: Dr. Wasserman, Dermatologist, Venice, FL:
- agreed to pay $26.1M to resolve allegations that he violated the False Claims Act (FCA) by:
  - Accepting kickbacks from a pathology laboratory &
  - Billing the Medicare program for medically unnecessary services

DOJ Nov 12: Dr. J. Natale, Vascular Surgeon, Arlington, IL:
- serving 10 month prison sentence for using CPT codes that allegedly represented more complicated procedures than the surgeries he performed
- Sentencing Judge: “accurate coding is of extraordinary importance”

(Source: Department of Justice Website)

Coding Complexity & Frequent Changes

Physician’s Concerns

Coder’s Responsibility

Incorrect Coding/Billing

Proper Action

Physicians & Coders
- Ethical responsibility to code services correctly
- Ethical duty to take action when become aware of unethical or inappropriate coding or billing

Compliance Program
- Offers guidelines
- Report and return overpayment 60 days from identification

Coding Change & Ambiguity

Rapid Changes & Annual Updates
- CPT – January 1
- ICD-10-CM- October 1

Conflicting policies
- Private Payers, CMS, Medicaid
- E/M Documentation Guidelines

Coding versus Billing

Physician’s Concerns

- Sometimes not aware of their responsibility
- Frequent changes in coding practice and policy
- Complexity & ambiguity
- Increased concern that unintentional mistakes in coding could lead to prosecution for Medicare fraud
Physician’s Responsibility

- Physicians are required to comply with all applicable statutes, regulations, and guidelines in order to be reimbursed by Medicare Part B.
- They have a duty to be knowledgeable in the statutes, regulations, and guidelines regarding coverage for Medicare services.
- Physicians certify that they are knowledgeable of Medicare’s requirements in the provider enrollment form they submit and each time they submit CMS 1500 claim form, or have such form submitted on their behalf.

Source: Physician Certification on CMS 1500 Claim Form

Increased Individual Accountability

- Government is increasing efforts to hold individuals accountable in order to change behavior.
- OIG has authority to exclude owners and managing employees from federal programs.
- Executives can be implicated by the “Responsible Corporate Officer Doctrine” (RCOD).

Coder’s Responsibility

- Held to a higher standard
  - Certifications’ Code of Ethics (AAPC & AHIMA)
  - Accurate coding is not only an ethical responsibility but also necessary to comply with federal laws
- Commitment to ethical professional conduct expected
- Refuse to participate in or conceal unethical practices
- Front end defense & offense
- Possible ethical dilemma-
  - Follow Chain of Command
  - Internal Compliance Program

Criminal and Civil Liability Examples

- DOJ 8/30/13: Former office manager for defunct Health Care Solutions Network Inc. (HCSN) in Miami sentenced to 68 months in prison for her role in fraud scheme that resulted in more than $63M in fraudulent claims.
- U.S.D.C., NY, 2003, Government indicted both the physician, Dr. Singh and his coder, Toni Coons for improperly upcoding claims and improperly billing incident to claims.
- FBI TX 2012: Former biller RGV DME - more than 11 years in Federal prison for role in $11M health care fraud scheme.

Up-coding

- Replacing the most appropriate code for service/procedure with a code for a more complex service.
- Unethical if done intentionally to provide higher reimbursement.
  - Provider says it’s level 4
  - You disagree – should you speak up?
  - Show me how to document all my visits as level 4

Examples of Unethical Practices

Up-coding & Unbundling
Medical Necessity
Inappropriate Use of Modifiers
Professional Courtesy
U.S. Warning to Hospitals on Medicare Bill Abuses

- NY Times 9/25/12: "There are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it's illegal."

Letter from Obama Administration on Hospital Billing
- American Hospital Association (AHA) Response to Obama Administration

Different Coding Pattern Among Physicians in Same Practice

The conflicting distribution of established office visits between the two physicians points to disparate coding methods and appears to be an anomaly.
- This type of conflict is often seen by carriers as an opportunity to conduct a review of the practice*

"Presumptive Coding"

- Only using one level of an E/M service in a category, will increases the risk for audit
- The physician is using CPT 99214 385% more often than his national compare group, significantly increasing his risk for third-party audits.

Unbundling

- Billing for multiple procedure codes for a group of procedures that are covered by a single comprehensive code
  - 2012 new CPT code 22633, prior to this service was reported with two procedure codes, 22630 and 22612
- Unintentional – misunderstanding of coding
- Intentional - increase reimbursement
- Ambiguity can lead to disagreement
- Consider seeking advice

Global Days & Payment

- CPT 22612 Lumbar Fusion (Arthrodesis, posterior or posterolateral technique, single level; lumbar)
  - "090" or 90 days
  - $1,659.50 Total Medicare Payment
    | Pre op | Intra op | Post op |
    | 10%    | 69%      | 21%     |
    | $165.95 | $1,145.06 | $348.50 |

- If the surgeon provided only the surgical portion of the procedure, the reimbursement would be based on 69% of the approved fee schedule amount, $1,145.06.

Modifier Compliance Risk - Are You an Outlier?

- Modifier -25 Usage
  October 2012: Georgia Cancer Specialist $4.1M settlement for misuse of modifier -25

*One physician can get the whole practice audited.
Medical Unnecessary Service: Inappropriate Admission

Implantable cardioverter defibrillator:
- Inpatient stay (HIPPS)
  - DRG 226 approximate payment $33,000.
- Outpatient stay (HOPPS)
  - APC 0108 approximately $25,000
  - Once denied, the hospital would only be allowed to rebill for certain ancillary services under Part B.
- Physician reports same CPT codes (MPFS)

Professional Courtesy

- Discount extended to physicians (or their immediate family members or office staff)
  - If discount offered and physician is covered under private insurance the plan must be notified (cannot accept insurance payments and waive co-pays)
  - May violate the federal anti-kickback statute if one purpose of the discount is to induce referrals of healthcare business paid by a Federal Healthcare Program
  - May violate state law if it can be construed as a bribe, kickback or illegal solicitation
  - Best practice: Create a policy and have legal review

Values & Common Sense

- Confusing rules & regulations
  - How will you know if you are doing the right thing?
  - Can you defend your decision?
- Values as your guide (yard stick/common sense)?
  - Legal?
  - Fair?
  - Does it feel right?

Compliance Program: 7 Components

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards
3. Designate a compliance officer or contact
4. Conduct appropriate training and education
5. Respond appropriately to detected offenses and develop corrective action
6. Develop open lines of communication with employees
7. Enforce disciplinary standards through well-publicized guidelines

Coder’s Responsibility If Fraud is Suspected

- Review documentation & research guidelines
  - Gather facts ahead of time to support correct coding
  - Make sure you are not mistaken
  - Collect information from more than one sources
  - Don’t take someone’s word for it
- Follow Chain of Command
  - Internal Compliance Program
- Possible Ethical Dilemma
  - Refer to AAPC/AHIMA code of ethics
  - Be true to your values
  - You may have to find another job

Government audits reinforce the importance of accurate coding
Best Practice

- Compliance Program vs Ethical Culture
- Examples set by leadership
  - Not just language in Code of Ethics
- Give employees examples of what is right and wrong within industry
  - Consistent reprimand if those lines are crossed

Summary

- Review your billing practices & analyze data;
- Use audits to assess the documentation for every physician in your practice;
- Document any issues identified and the training provided;
- Listen to the concerns of all employees;
- Have a conflict of interest protocol & non retaliation policies;
- Enforce accountability for everyone; and
- Return identified overpayments within 60 days!

Resources

- OIG Compliance Guidance for Small Physician Practices
- OIG New Physician Road Map
- AHIMA Code of Ethics
- AAPC Code of Ethics

CMS Provider Updates: Link to sign up:
- CMS Medicare FFS Provider e-News
  http://www.lexicle.com/decision/2004558390F3d168_1548

AAPC : Healthcare Business Monthly

Questions?

Thank you!

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