

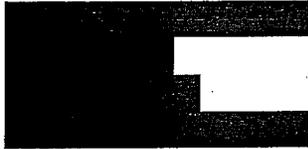


Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Bldg, 2nd floor, Cranston, RI 02920
phone: 401.462.2132 fax 401.462.0458

Docket # 15-234

[REDACTED]
Hearing Date: May 14, 2015

Date: July 2, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided in your favor you upon a de novo (new and independent) review of the full record of hearing. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION: 0301.20 Medicaid Providers Administrative Sanctions
SECTION 0300.40.10: Sanctionable Violations
ICD-9-CM Official Guidelines for Coding and Reporting**

The facts of your case, the Agency rules and regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page.

Copies of this decision have been sent to the following: [REDACTED]

[REDACTED]; Ben Copple, Esq (Chief Legal Counsel/EOHHS), Ralph Racca, (Administrator/ EOHHS Office of Program Integrity), and Julia Kogan, MD (Chief Medical Director/PRGX).

Present at the hearing were: [REDACTED]

[REDACTED] Ben Copple, Esq (Chief Legal Counsel/EOHHS), Ralph Racca, (Administrator/ EOHHS Office of Program

Integrity), Paula Giocastro (HP Claims Manager), and participating by phone: Julia Kogan, MD (Chief Medical Director/PRGX USA Inc.), and Messa Adjavon (RAC Contact Requirements Strategy/PRGX USA Inc.).

EOHHS RULES AND REGULATIONS:

Please see the attached APPENDIX for EOHHS MCAR

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

ISSUE: Did the hospital coding of the patient's conditions accurately represent the inpatient care provided?

TESTIMONY AT HEARING:

The EOHHS Administrator of Program Integrity, assisted by legal counsel, testified for the Agency:

- The Recovery Audit Contracting (RAC) program is federally mandated.
- As a state that provides Medicaid, Rhode Island chose PRGX as a RAC source through a bidding process, and entered into a contract agreement for their services.
- PRGX began reviewing in-patient medical record reviews for all hospitals in the state of Rhode Island receiving Medicaid payments.
- Subsequent to those reviews, certain claims that had been improperly paid were found.
- A letter of findings dated March 27, 2014 explained the reason PRGX determined that an overpayment had been made in this case (exhibit #2).
- An electronic claims receipt from Rhode Island Medicaid Management System (MMS) shows that the payment was generated to the hospital (exhibit #3).
- The claim had not yet been adjusted based on the PRGX findings.
- The difference would be approximately \$2400 less than the bill for the original claim previously paid by MMS.
- Coding Clinic directives are provided by the hospital association, but the ICD-9-CM coding guidelines have been cited as the appropriate guidelines for reporting hospital care.

- A hospital affiliated organization is not a relevant authority on the interpretation of official guidelines.
- Abnormal findings should not be coded unless the provider demonstrates the clinical significance.
- The severity of illness when moving from level two to level three is based on a payment methodology.
- The APR-DRG (All Patient Refined-Diagnosis Related Groups) takes the codes that are submitted for payment, groups those codes, and based on an algorithm, a DRG level is assigned.
- Based on the ICD-9-CM codes a level from one (lowest severity) to four (highest severity) is determined.
- In this case, based on the ICD-9 codes submitted for payment, codes were grouped to match a DRG level three.
- If the particular code assigned to carotid stenosis were to be omitted, the outcome would change to DRG level two.
- This is not a coding audit, it is a payment audit.
- Coding does impact the payment being made.
- Payment based on ICD-9 codes included although no treatment or care had been given for a particular diagnosis, would be considered an improper payment.
- The DRG, the relative weight assigned, and the base rate that is applied, vary each year as there is a new version released each October.
- The state made a policy decision to delay implementation of the new version until the following July, and to base the claims on the previous version in the interim.
- There is a slight variation between the rates PRGX calculated, and the adjustment computed when applying the current version used in RI.
- The state agency made an administrative agreement with the hospital to use the current version when settling claims.
- Based on the current method of calculation, the coding results directly impact payment.

- That was different under the previous system which was based on percentages, and not impacted by medical codes.
- The change to reliance on APR-DRGs has made the coding an issue.
- The Rhode Island rules and regulations and the provider agreement establish that the state cannot pay for services that were not rendered.
- Witnesses for both sides have testified that no additional treatment had been provided to the patient in this case for carotid stenosis.
- Carotid stenosis was an incidental finding from a CT scan of the chest.
- There was no specific test performed to determine the severity of carotid stenosis.
- It is unknown if the condition was chronic, because there are no prior primary care records, just hospital records.
- The provider agreement (agency exhibit #5) would be submitted as evidence.
- A letter dated February 19, 2015 indicating points of authority supporting EOHHS action to seek recovery of improper payments (agency exhibit #6) would also be submitted.
- The agency is not alleging that any fraudulent claims have been filed, but does maintain that inappropriate payments have been made.
- The agency is not asking the hospital to change their medical records, but wants consideration of the impact coding additional services that have not actually been rendered has on billing.
- The state is not required to pay for those situations.

The PRGX Chief Medical Director, assisted by legal counsel, testified for the Agency:

- She is a medical doctor, board certified in internal medicine.
- She has worked as a physician since 1986.
- She has been reviewing medical records for RAC throughout the last eight years.

- She examines medical records to establish medical necessity as well as appropriate coding.
- She is licensed as a physician in Rhode Island.
- Her role in the audit process is to review the medical records and to validate that the findings are correct according to the coding rules.
- Her opinion was based on medical records and ICD-9-CM coding guidelines.
- The findings were originally drafted by a coder, and later reviewed by the physician.
- She examined medical records of the patient's hospitalization following a motor vehicle accident (MVA).
- A CT scan of the chest was performed which also revealed a blockage of the carotid artery.
- Carotid stenosis and acidosis were indicated in the records as complicating conditions, although they are unrelated.
- The provider had coded carotid stenosis as a complicating condition influencing hospital care.
- According to Section III (B) of the coding guidelines, diagnostic findings are not coded and reported unless the provider can establish their clinical significance.
- Notes of the attending hospital physician did not indicate the clinical significance of the CT scan results.
- Based on the lack of information regarding the clinical significance of the finding, (carotid stenosis) should not have been coded.
- No additional tests were ordered to further evaluate carotid stenosis.
- No treatment for carotid stenosis was ordered.
- No additional services were performed.
- The CT scan performed was intended to evaluate the chest (usually covering the lungs, diaphragm, and part of the liver), and would not give the best information relative to the carotid artery located in the neck.

- The top portion of the image only captures a very short area of the neck.
- The carotid artery extends all the way to the jawline.
- A dedicated ultrasound of the neck would be required to more accurately examine that artery.
- Otherwise a CT angiogram with dye injected into the vessel would be another option.
- They did not do anything additional to ascertain that the patient really had carotid stenosis.
- The finding was an incidental finding on a diagnostic study and did not require clinical evaluation, therapeutic treatment or extended length of stay.
- The DRG (Diagnosis Related Group) which establishes level of severity was impacted by the coding of carotid stenosis.
- As the inclusion of the additional diagnosis raised the indicator of the severity level, it also raised the cost of services.
- The fact that the attending physician did not proceed with any further testing or evaluation of the condition proves that it should not have been included among the services provided.
- The guidelines are international and used in all US states including Rhode Island.
- The same guidelines were applied to reviews of other cases of the same hospital that had been reviewed by PRGX in the past.
- A chronic condition is a condition that is treatable, but not curable, and may be of significant duration.
- In order to define severity of stenosis of a carotid artery, it would need to be diagnosed by ultrasound.
- That test was never performed.
- Furthermore, there was no follow up.
- The severity of illness was not established for carotid stenosis in this case, because he was being treated for a different primary condition.

The Director of Inpatient Coding, assisted by legal counsel, testified for the Appellant:

- She is a Registered Health Information Administrator (RHIA), and a Certified Coding Specialist (CCS).
- She has been employed by the hospital since 1985 and has worked as both a Manager and Director of a coding department.
- She requested to submit a CV summary of her education and experiences (appellant exhibit #1).
- RHIA qualifies her to manage, and to know the regulations for management of the entire record department, which includes knowledge of the legal medical records privacy, confidentiality, and coding rules.
- CCS is given for mastery in patient coding by the American Health Information Management Association.
- She is currently employed as Director of Health Information Coding.
- She oversees inpatient coding for two hospitals as well as the observation coding for those hospitals.
- She is also involved in the education program for hospital coders.
- She has been trained in the use of ICD-9-CM coding guidelines.
- She received a request from PRGX suggesting that the hospital delete the code identifying carotid stenosis as a secondary diagnosis.
- Because the case involved a trauma patient, carotid stenosis was considered an additional diagnosis.
- A letter to PRGX dated April 18, 2014 and signed by an Inpatient Coding Validator with attached supportive medical records was submitted as evidence (appellant exhibit #2).
- Carotid stenosis was documented in the history and physical section of the medical record.
- While referencing the CT scan the physician described the condition as "Extensive".
- The coding guidelines require coding of any secondary diagnosis that is reported in the record.

- They are also required to code conditions in medical records that are labelled "chronic".
- The coding of carotid stenosis was based on the factors that the diagnosis appeared within the body of the medical record, was labelled as a chronic condition, and was observed to be extensive.
- Other chronic conditions within that same medical record had been coded, but they were not asked to delete those codes.
- The primary diagnosis was the traumatic condition that resulted in the patient's admission to the hospital.
- Any secondary diagnosis that coders are required to report would be outlined on page 91 (Section III Reporting Additional Diagnoses) of the coding guidelines.
- Five rules for establishing whether treatment requires coding include: clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of stay, and increased nursing care or monitoring.
- In this matter clinical evaluation was documented, a diagnostic CT scan had been ordered, and monitoring occurred.
- All conditions that coexist during an admission should be reported.
- The Coding Clinic is an authoritative publication that is referred to for specific coding problems.
- There are two Coding Clinic explanations that support the requirement to code the secondary condition as done in this case.
- One publication from July 1985 stated that chronic conditions must be coded.
- Another edition published in 2007 indicated that they must code chronic conditions even if only mentioned in the history.
- She believes that carotid stenosis was appropriately coded, and that it would be improper to delete that code.
- Her position is supported by the ICD-9-CM guidelines, the UHDDS (Uniform Hospital Discharge Data Set), and the Coding Clinic publications.
- Coding Clinic publications are provided by several organizations such as the American Hospital Association (the copy referred to in this case).

- The auditors (PRGX) for the agency used multiple references to Coding Clinic directives as support for their decisions.
- Coding Clinic explanations are used by certified coders and recovery audit contractors alike.
- She agreed with the content of the letter of April 18, 2014 (exhibit #2), and felt that she understood the physician's intent, although she did not question him directly.
- She believes that she would be non-compliant with the ICD-9-CM guidelines if she were to omit or delete coding of a condition according to CMS requirements.
- The physician expressed the clinical significance of the finding of carotid stenosis when he labelled it "extensive".
- Coders are not allowed to assign codes based directly on diagnostic findings, and must rely on the documentation of the attending physicians.
- The condition would not have been coded had the physician not entered the diagnosis into the body of the record.
- Otherwise, coders would be expected to query the physician for clarification.
- This case involves more than a billing dispute, because the agency is objecting to the severity of illness code.
- The severity of illness gives the physician credit for the care that is given.
- There were no additional tests after the CT scan was taken that were ordered to further evaluate carotid stenosis.
- Although no further evaluation or prescribed treatment of the condition was indicated, the entry still deserved to be coded.
- Once the medical record is completed and coded for billing, there is no further review by a physician.
- The coders are trained to read and understand the medical records, and apply the rules uniformly, as opposed to making clinical decisions.
- A physician with no coding experience would not necessarily be qualified to code medical records.

- The coding in this case was based on the general rules for Additional Diagnoses rather than the provisions found under Abnormal Findings (Section III B).
- The conclusion to code carotid stenosis is consistent with instructions offered in the Coding Clinic responses.
- Entry of a diagnosis could impact the treatment of a patient over time, even if it is noted daily.
- There was no query of the physician performed in this matter, because it was clear.
- When examining the medical records, there are many abnormal findings remain not coded because they have not been documented by a physician.
- The coders only query the doctor if information is vague or unspecified.
- If a doctor singles out a diagnosis to include in the record, than that indicates the abnormality is clinically significant.
- She believes that carotid stenosis is a chronic condition, but must code what is treated regardless of whether or not it is chronic.
- The treatment was the clinical evaluation.
- Coding is usually completed soon after treatment is given.

The Director of Clinical Documentation, Integrity, and Appeals testified for the Appellant:

- She is a registered nurse.
- She is also a certified coder and works closely with the coding department.
- Coders rely on four references including the Coding Book, the UHDDS, and the Coding Clinics, in addition to the ICD-9-CM Coding Guidelines.
- The records must be considered in their entirety to support the accuracy of coding a diagnosis.

- The patient did have a CT scan which was part of the medical record, and was reviewed by the physician.
- The physicians typically pull out and document any additional conditions that are found to be clinically significant.
- The patient sustained trauma from a motor vehicle accident and probably had more than one CT scan which revealed extensive carotid stenosis.
- He also had hypertension and diabetes which are often present with carotid stenosis.
- That very important artery (the carotid artery) leads to the brain.
- The stenosis of the artery was important to note, because the decrease of the blood flow to the brain was of clinical significance for establishing future care.
- The coders rely on the physician's words to place value on the care given to patients.
- Codes are also used for research and epidemiology, so the accuracy is important.
- As the patient's treatments for hypertension and diabetes were maintained throughout his hospital admission, in essence, his carotid stenosis was being treated.
- He was also on a lipid lowering medication which would also be prescribed for a patient with carotid stenosis.
- All of the information gathered is important to his primary care physician in order to facilitate continued treatment.
- He probably will require some type of surgery, which would not be completed during his hospitalization for the MVA trauma.
- They would, however, monitor blood pressure and blood sugar, and be certain he took appropriate medications to benefit the carotid stenosis condition while in their care.
- The particular diagnosis of carotid stenosis carries great weight, as it increases the patient mortality concerns.

- The various available coding reference materials need to be considered in combination, as the guidelines alone can be weak in certain areas.
- The coding book should come first.
- Any chronic condition that would impact the rest of a patient's life is important.
- Every year (in October) the coding guidelines are updated, and the appropriate guidelines for the time during which the hospitalization occurred are used to code each case.

FINDINGS OF FACT:

- The Agency issued a written notice dated August 14, 2014 for "Recovery of Improper Payments" (aka the "demand letter") pursuant to findings of PRGX USA Inc. Recovery Audit Contracting (RAC) program that an overpayment had occurred.
- The notice of August 14, 2014 did inform the appellant of the right to a hearing, but did not provide specific references to findings, rules, or regulations that would support the repayment demand as required by 42CFR431.205 (a)(b)(c).
- The appellant filed a timely request for hearing received by the EOHHS Appeals Office on September 15, 2014.
- On the date the appeal was received, a written complaint was included, indicating that the appellant challenged the overpayment identified in the demand letter with specific emphasis on the importance of coding.
- Per the appellant's request, the record of hearing was held open through the close of business on May 22, 2015 for the appellant to submit additional evidence including the medical records of the patient's hospitalization.
- Per the agency's request, a response to the submission of additional evidence could be entered through the close of business on June 1, 2015.
- Additional evidence including: a copy of the first page of the ICD-9-CM Official Guidelines for Coding and Reporting (Appellant exhibit #3), a copy of the UHDDS (Uniform Hospital Discharge Data Set) (Appellant exhibit #4), a copy of the Coding Clinic guideline for coding chronic conditions dated July-August 1985 (Appellant exhibit #5), a copy of the Coding clinic

clarification for coding of chronic conditions dated Third Quarter 2007 (Appellant exhibit #6), and patient medical records for July 7, 2013 to July 8, 2013 was received and added to the record of hearing.

- At the close of business on June 1, 2015, no response to the submission of additional evidence had been received from the Agency.
- The patient was hospitalized primarily to evaluate effects of trauma secondary to a motor vehicle accident.
- The ICD-9-CM coding guidelines allow historical medical conditions that impact patient care to be coded as a secondary diagnosis.
- Evidence established that the patient's medical history of carotid stenosis as included in the history and physical portion of the records was evaluated and treated by the provider.
- The ICD-9-CM Official Guidelines for Coding and Reporting Section III General Rules for Other (Additional) Diagnoses define "other diagnoses" as additional conditions that affect patient care.
- The patient's medical history, diagnostic imaging results, and therapeutic treatment supported the clinical significance of his carotid stenosis, and the impact it would have on current care.
- Carotid stenosis was appropriately coded as a secondary diagnosis.
- Coding is consistent with the services rendered to the Medicaid beneficiary, and therefore, did not result in overbilling in this case.

DISCUSSION OF THE MEDICAL EVIDENCE RECORD:

The record of hearing consists of:

- ✓ An EOHHS Notice, Subject: Recovery of Improper Payments dated August 14, 2014, and unsigned. (Agency exhibit #1)
- ✓ An EOHHS Notice of Findings dated March 27, 2014 explaining the results of an audit supporting the conclusion that an overpayment had been issued (Agency exhibit #2).
- ✓ A CV documenting the credentials and experience of the Director of Inpatient Coding (Appellant exhibit #1).
- ✓ A letter of response to PRGX findings dated April 18, 2014, and signed by an Inpatient Coding Validator with attached supportive medical records (Appellant exhibit #2).
- ✓ A copy of the first page of the ICD-9-CM Official Guidelines for Coding and Reporting (Appellant exhibit #3).
- ✓ A copy of the UHDDS (Uniform Hospital Discharge Data Set) (Appellant exhibit #4).
- ✓ A copy of the Coding Clinic guideline for coding chronic conditions dated July-August 1985 (Appellant exhibit #5)
- ✓ A copy of the Coding clinic clarification for coding of chronic conditions dated Third Quarter 2007 (Appellant exhibit #6).
- ✓ Rhode Island Medicaid Management Information System Adjudicated Claim Information (Agency exhibit #3).
- ✓ The ICD-9-CM Official Guidelines Section III (Agency exhibit #4).
- ✓ A copy of a Medicaid Provider Agreement and Addendum 1 undated and unsigned (Agency exhibit #5).
- ✓ A letter dated February 19, 2015 signed by Ralph Racca, listing EOHHS points of authority supporting action to seek recovery of improper payments (Agency exhibit #6).
- ✓ Patient medical records documenting the hospital care for July 7, 2013 to July 8, 2013.
- ✓ Hearing testimony.

In this matter, the appellant's representative has argued that appropriate procedure was followed when coding a secondary diagnosis of carotid stenosis based on the rules established by the ICD-9-CM Official Guidelines for Coding and Reporting. The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U S Federal Government's Department of Health and Human Services (DHHS) provide the guidelines for coding and reporting. Adherence to the guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA). Additionally, the hospital coders rely on the Coding Book, Coding Clinic directives, and the UHDDS. A combination of those sources guides all coding decisions.

The introduction to the ICD-9-CM document notes:

*"The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation, accurate coding cannot be achieved. The **entire record** should be reviewed to determine the specific reason for the encounter and the conditions treated."*

Review of the complete medical record allowing for consideration of all facts within the context of the entire patient experience during the hospital admission is essential, although results are highly dependent upon the accuracy and clarity of the details provided by the treating physician(s). Justifying the existence of a secondary condition warranting coding would depend upon complete and consistent documentation of treatment that was supported throughout the medical record by objective findings. The Agency representative emphasized the importance of establishing the clinical significance of a diagnosis, and providing evidence that services were actually rendered to the Medicaid beneficiary when determining how the care would impact the amount billed.

The RAC Medical Director is considered a non-examining source when expressing an opinion regarding the severity of a patient condition based solely on medical records. At the time of the recovery audit, the medical review indicated that a single CT scan of the chest had been performed, which was not the ideal diagnostic tool for establishing the severity of blockage in the carotid arteries. Consequently, the agency considered the finding to be "incidental". While that statement would make a valid point, an appellant representative testified that several CT scans had been performed, and provided evidence of six different diagnostic tests performed on July 7, 2013 including a studies of the neck and of the brain, which clearly could be affected by the reduced blood flow from the carotid arteries. Consequently, it has been established that imaging of chest views cited during agency testimony was not the only diagnostic information the attending physician had to rely on. The treating physician emphasized in his medical record entry that the calcification was "extensive".

Section III General Rules for Other (Additional) Diagnoses notes that:

"For reporting purposes, the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring clinical evaluation; or therapeutic treatment or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring. "

The understanding of what constitutes treatment as captured in the language of this rule is highly significant. The guidelines have established that a variety of methods of care that may be offered in a hospital setting may be considered the equivalent of treatment for the purpose of establishing and coding additional diagnoses. For the rationale of this decision, consideration is given to the broad definition of treatment established by CMS within the coding guidelines.

Representatives for the appellant maintain that carotid stenosis was evaluated and treated during the hospital stay. The condition was documented repeatedly while noting significant level of severity. Recent diagnostic imaging results were compared with those performed on November 13, 2012. The comparison scan of the head documented that vasculature findings included calcified atherosclerosis of the carotid arteries bilaterally.

Subsection III Reporting Additional Diagnoses

A) Previous conditions:

"If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

*However, history codes (V10-V19) may be used as secondary codes if **the historical condition or family history has an impact on current care or influences treatment.**"*

In this matter the historical condition did have an impact on the current treatment. While carotid stenosis did not appear in the discharge diagnosis list, it was indicated as part of the history and physical. Although it was not directly related to the trauma of the MVA that brought the patient to the hospital on that particular date, it clearly was chronic; as it is a condition that would not occur spontaneously, and that had progressed over a significant span of time.

Due to the patient's elevated risk of cerebrovascular accident from impaired blood flow, carotid artery blockage is a condition that a responsible treatment provider would not be likely to ignore. The attending medical staff did provide treatment as needed for blood pressure, diabetes, and lipid levels which were all risks factors requiring control in a patient with a longitudinal history of calcified atherosclerosis affecting carotid arteries. Acceptable clinical and diagnostic findings verified that the blockage was extensive as reported by the attending physician. Results of those findings have established the clinical significance of the condition, and would allow the physician to determine whether or not any further action was required based on the patient's immediate needs and risk factors. While additional workups were not ordered in the context of a hospital admission for MVA trauma, useful information was obtained for the patient's continued care with his regular treating physicians.

CONCLUSION:

As established within the Rhode Island Code of Medicaid Rules section 0301 relative to Payments and Providers,..." payments to certified providers for authorized services must be made in accordance with methodologies established by the State and approved for such purposes by the Secretary of the US Department of Health and Human Services (DHHS) and/or the federal Centers for Medicare and Medicaid Services (CMS). The Secretary of the EOHHS is authorized to set forth in rule, contractual agreements, provider certification standards, and/or payment methodologies the requirements for obtaining federal financial participation established in federal laws, regulations, or other such authorities. This rule governs participation of and payments to health care providers participating in the Medicaid program."

Title 40 Section 40-8.2-3 addresses Prohibited Acts in the context of Medical Assistance Fraud. The agency, in this matter, has entered into an agreement documented in writing on March 9, 2015 and clarifying that, although the agency cited fraud policy while arguing that unjustified spending had occurred, they were not alleging that the appellant provider had willfully committed fraud during this transaction. The clarification was made pursuant to the agency citation of the statute referenced above to indicate a similarity of the consequences when both fraudulent claims and discrepancies in coding methods impacting billing result in overpayment for the services provided. The Rhode Island EOHHS provider agreement indicates in pertinent part, that claims submitted should document..."that the goods or services listed were medically necessary... and actually rendered to the RIMAP beneficiary."

DHS regulation 0300.40.15 indicates that sanctions may be imposed by the agency against a provider for presenting for payment, an inaccurate claim for medical services. A finding was made by the agency's recovery audit contractor (RAC) that a discrepancy existed between the coding of services rendered as assigned by the provider, and the coding guideline interpretation used by the auditor. Subsequently, the agency notified the appellant of the anticipated overpayment. A rebuttal process had been attempted to resolve the differences. After exchange of further points of explanation without resolution, the agency initiated recovery procedures to recoup the alleged overpayment per 0330.40.20 (viii), and the appellant filed a timely request for administrative appeal.

In summary, the patient was admitted for treatment due to trauma sustained during a motor vehicle accident. Records documented insufficiencies of the carotid arteries secondary to blockage that has been viewed by diagnostic imaging completed during hospitalization in July 2013, as well as in studies taken the previous year and used for comparison. Review of the entire record reveals that the condition was known by medical history, and status of the condition was updated by acceptable clinical and diagnostic evaluations performed during the July 2013 hospital admission. Clinical significance of carotid stenosis was

recognized by the treating physician, and maintenance medications were provided. The historical condition was coded as a secondary diagnosis, and did have an impact on patient care. As a result, the original coding and subsequent calculation of severity and cost of service was consistent with the care actually provided to the patient.

After careful and considerate review of the regulations and guidelines, as well as the evidence and testimony submitted, this Appeals Officer concludes that the appellant has justifiably reported the care provided to the Medicaid recipient and patient in this case, according to the rules established by the Coding Book, ICD-9-CM Official Guidelines for Coding and Reporting, USDDS, and Coding Clinic parameters.

Pursuant to DHS Policy General Provisions section 0110.60.05, action required by this decision, if any, completed by the Agency representative must be confirmed in writing to this Hearing Officer.



Carol J. Ouellette
Appeals Officer

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

APPENDIX

ICD-9-CM Official Guidelines for Coding and Reporting

Effective October 1, 2011

Narrative changes appear in bold text

Items underlined have been moved within the guidelines since October 1, 2010

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). These guidelines should be used as a companion document to the official version of the ICD-9-CM as published on CD-ROM by the U.S. Government Printing Office (GPO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-9-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are included on the official government version of the ICD-9-CM, and also appear in "*Coding Clinic for ICD-9-CM*" published by the AHA.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in Volumes I, II and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

- clinical evaluation; or
- therapeutic treatment; or
- diagnostic procedures; or
- extended length of hospital stay; or
- increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc).

The following guidelines are to be applied in designating “other diagnoses” when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

A. Previous conditions

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other

tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

- Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

0301 Payments and Providers

0301.01 Scope and Purpose

The Rhode Island Medicaid program provides health care coverage authorized by Title XIX of the Social Security Act (Medicaid law) and Title XXI (federal Children's Health Insurance Program (CHIP) law) as well as the State's Section 1115 demonstration waiver. To participate in the Medicaid program, health care providers must be certified and agree to abide by the requirements established in Title XIX, Title XXI, Rhode Island General Laws, and State and federal rules and regulations. To qualify for federal matching funds, payments to certified providers for authorized services must be made in accordance with methodologies established by the State and approved for such purposes by the Secretary of the U.S. Department of Health and Human Services (DHHS) and/or the federal Centers for Medicare and Medicaid Services (CMS). The Secretary of the BOHHS is authorized to set forth in rule, contractual agreements, provider certification standards, and/or payment methodologies the requirements for obtaining federal financial participation established in federal laws, regulations, or other such authorities. This rule governs participation of and payments to health care providers participating in the Medicaid program.

0300.40 Procedure for Imposing Administrative Sanctions

0300.40.05 Statutory Authority

REV: 08/2007

In accordance with Title 42 Chapter 35 of the General Laws of Rhode Island (The Administrative Procedures Act), Title 40 Chapter 8.2, the Rhode Island Department of Human Services hereby establishes administrative procedures to impose sanctions on providers of medical services and supplies for any violation of the rules, regulations, standards or laws governing the Rhode Island Medical Assistance Program. The Federal Government mandates the development of these administrative procedures for the Title XIX Medical Assistance Program in order to insure compliance with Sections 1128 and 1128A of the Social Security Act, which provides for federal penalties to be imposed for activities prescribed therein.

0300.40.10 Definitions

REV: 09/2010

As used hereafter, the following terms and phrases shall, unless the context clearly required otherwise, have the following meanings:

Rhode Island Medical Assistance Program - established on July 1, 1966, under the provisions of Title XIX of the Social Security Act, as amended (P. L. 89-97). The enabling State Legislation is to be found at Title 40, Chapter 8 of the Rhode Island General Laws, as amended.

Department - the Rhode Island Department of Human Services which is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medical Assistance Program.

Director - the Director of the Rhode Island Department of Human Services.

Provider - any individual, firm, corporation, association, institution or group qualified or purporting to be qualified to perform and provide the medical services and supplies, which are within the scope of the services covered by the Rhode Island Medical Assistance Program.

Statutory Prerequisites - any license, certificate or other requirement of Rhode Island law or regulation which a provider must have in full force and effect in order to qualify under the laws of the State of Rhode Island to perform or provide medical services or to furnish supplies. The prerequisites include but are not limited to, licensure by the Rhode Island Department of Health, the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (DBHDDH), certification for participation in the Federal Medicare Title XVIII Program and any other legal requirement pertinent to the delivery of the specific medical services and supplies. The term statutory prerequisite includes any requirement imposed by this Department through duly promulgated administrative regulations.

State Health Care Program - includes but not limited to those programs defined in section 1128 (h) of the Act such as those totally state-funded and administered by the Department.

0300.40.15 Sanctionable Violations

REV: 08/2007

All providers of medical services and supplies are subject to the general laws of the State of Rhode Island and the rules and regulations governing the Rhode Island Medical Assistance Program. Sanctions may be imposed by the Department against a provider for any one (1) or more of the following violations of applicable law, rule or regulation:

- (i) Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.
- (ii) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.
- (iii) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.
- (iv) Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medical Assistance recipients and records of payments made for such services.
- (v) Failure to provide and maintain quality services to Medical Assistance recipients within accepted medical community standards as determined by an official body of peers.
- (vi) Engaging in a course of conduct or performing an act deemed improper or abusive of the Medical Assistance Program or continuing such conduct following notification that said conduct should cease.
- (vii) Breach of the terms of a Medical Assistance provider agreement or failure to comply with the terms of the provider certification of the Medical Assistance claim form.
- (viii) Over-utilizing the Medical Assistance Program by inducing, furnishing or otherwise causing a recipient to receive services or supplies not otherwise required or requested by the recipient.
- (ix) Rebating or accepting a fee or portion of a fee or charge for a Medical Assistance recipient referral.
- (x) Violating any provisions of applicable Federal and State laws, regulations, plans or any rule or regulation promulgated pursuant thereto.
- (xi) Submission of false or fraudulent information in order to obtain provider status.
- (xii) Violations of any laws, regulations or Code of Ethics governing the conduct of occupations or professions or regulated industries.
- (xiii) Conviction of a criminal offense for any intentional, reckless, or negligent practice resulting in death or injury to patients.
- (xiv) Failure to meet standards required by State or Federal laws for participation such as licensure and certification.
- (xv) Exclusion from the Federal Medicare Program or any state health care program administered by the Department because of fraudulent or abusive practices.
- (xvi) A practice of charging recipients or anyone in their behalf for services over and above the payment made by the Medical Assistance Program, which represents full and total payment.
- (xvii) Refusal to execute provider agreement when requested to do so.
- (xviii) Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.
- (xix) Formal reprimands or censure by an association of the provider's peers for unethical practices.
- (xx) Suspension or termination from participation in another governmental medical program such as Workers' Compensation, Children With Special Health Care Needs Program, Rehabilitation Services, the Federal Medicare Program, or any

- state health care program administered by the Department.
- (xxi) Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.
 - (xxii) Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments.

0300.40.20 Provider Sanctions

REV: 08/2007

Any one (1) or more of the following sanctions may be imposed against providers who have committed any one (1) or more of the violations contained in Section 0300.40.15, above:

- (i) Termination from participation in the Medical Assistance Program or any state health care program administered by the Department.
- (ii) Suspension of participation in the Medical Assistance Program or any state health care program administered by the Department.
- (iii) Suspension or withholding of payments.
- (iv) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement.
- (v) Prior authorization required before providing any covered medical service and/or covered medical supplies.
- (vi) Monetary penalties.
- (vii) Prepayment audits will be established to review all claims prior to payment.
- (viii) Initiate recovery procedures to recoup any identified overpayment.
- (ix) Except where termination has been imposed a provider who has been sanctioned may be required to attend a provider education program as a condition of continued participation in any health care program administered by the Department. A provider education program will include instruction in: (a) claim form completion; (b) the use and format of provider manuals; (c) the use of procedure codes; (d) key provisions of the Medical Assistance Program; (e) reimbursement rates; and (f) how to inquire about procedure codes or billing problems.

0300.40.35 Administrative Hearing

REV: 08/2007

The right to an administrative appeal is conditioned upon the appellant's compliance with the procedures contained in these regulations and the hearing will be held in compliance with the provisions of the State's Administrative Procedures Act, as found at RIGL 42-35, as amended, and in conformance with DHS Policy Section 0110 et al.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.