



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 # 15-189

[REDACTED]
Hearing Date: February 12, 2015
Reconvened: May 14, 2015

Date: June 9, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against 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/OHHS), Ralph Racca, (Administrator/ EOHHS Office of Program Integrity), and Julia Kogan, MD (Chief Medical Director/PRGX).

Present at the hearing were: [REDACTED]

[REDACTED] Paula Giocastro (HP Claims Manager), Ralph Racca, (Administrator/ EOHHS Office of Program Integrity), and participating by phone: Julia Kogan, MD (Chief Medical

Director/PRGX USA Inc.), and Jeffrey Harding (Director of Healthcare Audit, Research, and 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 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 employs experts who are qualified to review and advise the agency if a claim has been paid at the proper rate.
- First PRGX requests medical records from the hospital, and reviews the documentation of services provided.
- PRGX professionals identify, according to reviewer opinion, any discrepancies in the coding of services affecting billing for the case in question.
- Upon notifying the hospital of their opinion that an error had been made, PRGX allowed an opportunity for the hospital to rebut that opinion.
- The hospital had thirty days to respond to the findings.
- The rebuttal process occurred prior to the filing of an administrative appeal request in this case.
- PRGX reviewed the hospital rebuttal.
- When PRGX agrees with the hospital justification, no further action is taken, and the case dispute is ended.

- As PRGX disagreed with the supplemental information provided during the rebuttal process, written notification stating their position was issued.
- That notification letter was followed by a demand notice specifying an estimated dollar amount expected for recovery.
- If no money is received within 30-45 days, the agency adjusts the claim according to the findings submitted by PRGX.
- Because the claims are retrospective, the state uses APR-DRGs (All Patient Refined-Diagnosis Related Groups) which are updated every year to the appropriate version.
- There can be slight variations of the estimated dollar amount.
- The final number is the number the provider receives in their RA (remittance advice).
- PRGX is obligated to defend their findings under the contract agreement they have with the state.
- The agency administrator requested that PRGX have a certified coder available on the telephone call during the hearing.
- A June 18, 2013 Notice of Findings was submitted as evidence (Agency exhibit #2).
- Regardless of whether or not the coding regulations require the coding of a particular condition, the primary focus should be on the issue that Medicaid cannot be expected to pay for services never offered.

The PRGX Chief Medical Director testified for the Agency:

- She is a medical doctor, board certified in internal medicine.
- She has worked as a physician for twenty five years.
- She has been reviewing medical records for evaluation of clinical information as well as for coding purposes throughout the last eight years.
- She would lead the presentation, and her associate would add information as needed.
- The patient is a 64-year-old female who has metastatic uterine cancer.

- She presented with a low grade fever and intermittent confusion.
- She was admitted for delirium due to progression of her metastatic disease.
- The provider used code 584.9 indicating acute renal failure (AKI) as an additional complicating condition.
- Review of the medical record does not support the use of the code 584.9.
- The record upon which they based their coding was a progress note of December 7, 2010 which happened to be the day before discharge.
- The progress note established that a slight rise in creatinine was to be monitored (on the following day).
- The hospital coder used that note to support the coding of acute renal failure 584.9.
- Coding guidelines require that the entire record be used to establish if the appropriate diagnoses and procedures were identified.
- The diagnosis (acute renal failure) was not established, and treatment was not provided, therefore making the coding of that condition as a secondary diagnosis inappropriate.
- Neither the admitting diagnoses nor the discharge diagnoses cited in this case include acute renal failure.
- The discharge diagnosis revealed that cancer had affected the brain, and that she had acquired a urinary tract infection.
- Creatinine was exactly the same on admission as it was at discharge.
- There was only one increase in creatinine to 1.13 during her stay.
- Even though there was a slight rise in creatinine, it would not constitute acute renal failure, and records do not demonstrate that it was treated as such.
- As the condition was never addressed, it should not be coded as a secondary diagnosis.
- When there is a clear inconsistency in the record, the coder is required to seek clarification from the physician.

- Because renal failure was not documented in subsequent medical records, and was not used in the discharge summary, it does not rise to a level to be coded as a secondary diagnosis.
- The doctor's note suggesting follow up does not mean that the condition was established.

The PRGX Director of Healthcare Audit, Research, and Strategy testified for the Agency:

- There was no mention of the condition in the medical records after the note that suggested follow up.
- Because there was no further mention of the condition or assessment after that, and because there was a question about whether or not there would be any follow up, (the coders) needed to query the physician.
- The physician stated, "Slight raise in creatinine, will monitor in the AM", which was the only mention of record.
- At the time of discharge, medical staff did not even refer to the condition as "possible".

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).
- 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.
- CCS is given for mastery in patient coding by the American Health Information Management Association which she earned in 1993.
- She has been coding since 1981.
- She has served as an expert coding witness in court cases for two law firms.
- She has held several management positions.
- Her current job title is Director of Inpatient Coding Services.

- She believes that coding of acute renal failure was correct.
- The condition was documented by the attending physician.
- Records stated that AKI would be addressed with monitoring of creatinine in the morning.
- The regulations provided by Medicaid indicate that monitoring signifies treatment; therefore, they are required to code that condition.
- The auditor has repeatedly argued that a diagnosis not used in the discharge summary should not be coded.
- A diagnosis does not need to be present in the discharge summary, as that is a synopsis of the medical record.
- A diagnosis does need to be present in the body of the record.
- As AKI was present within the body of the record, it was coded.
- The Coding Regulations on page 91/107 Section III establish that monitoring is a term equated with treatment, substantiating that the coding was correct.
- A copy of the November 25, 2010 treatment note was offered as evidence that the condition had been entered (appellant exhibit #2).
- A copy of the ICD-9-CM Official Guidelines for Coding and Reporting was submitted as evidence (appellant exhibit #3).
- Coders are required, if there is an inconsistency in the medical record, to bring that to the doctor's attention.
- A diagnosis listed at discharge after test results had been negative, is an example of the type of inconsistency that coders would query.
- As there was no inconsistency in this matter, the coder was required to code AKI which records indicate was monitored and diagnosed.
- The doctor never ruled out the existence of the condition, and therefore, if it is present, they must code it.

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.
- 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 of appeal, a written complaint indicated that the appellant challenged the overpayment identified in the demand letter with specific emphasis on the importance of coding.
- The hearing scheduled for January 29, 2015 was rescheduled to February 12, 2015.
- The record of hearing was held open through the close of business on February 19, 2015 for Agency submission of a federal regulation clarifying Medicaid payment requirements.
- Per the appellant's request the record was held open through the close of business on February 26, 2015 to allow time for a response to new Agency submissions or to make a request to reconvene.
- Additional evidence including a Medicaid Provider Agreement and Addendum 1, Rhode Island Medicaid Rules and Regulations #0301.20 and #0300.40.15, and Rhode Island General Law, GL 40-8.2-3 was submitted by the Agency on February 19, 2015.
- Appellant response to the new evidence was received on February 26, 2015.
- A request for extension of the held-open period to allow time for the parties to form an agreement with respect to the intent of the agency's submission of regulations, or to request a reconvene of the hearing was made by legal counsel for the appellant, and additional time was granted until the close of business on March 9, 2015.
- A written agreement established between the appellant and the agency was submitted on March 9, 2015.

- The evidence record was reopened by the Appeals Officer for further development of the medical evidence records.
- On May 14, 2015, the hearing was reconvened for the submission of evidence consisting of complete medical records of the patient's hospital admission for November 24, 2010 to December 8, 2010.
- Evidence revealed that the patient had been treated for fever and delirium secondary to metastatic brain disease and a urinary tract infection.
- She also had a history of endometrial carcinoma, heart disease, stroke, diabetes, chronic obstructive pulmonary disease, and morbid obesity.
- The ICD-9-CM coding guidelines allow historical medical conditions that impact patient care to be coded as a secondary diagnoses.
- No history of prior renal failure or insufficiency had been indicated.
- Routine laboratory tests including creatinine levels were taken each day of her admission.
- Creatinine levels were normal for the first thirteen days, as well as on the fifteenth day, which was the day of discharge.
- There was a slight increase of creatinine on day fourteen only.
- Monitoring for renal impairment was suggested for the following morning.
- 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.
- Records did not document any change of patient care, any additional clinical evaluations, diagnostic procedures, or therapeutic treatment specific to renal conditions.
- Records did not document any required increase of skilled nursing care or monitoring.
- The length of the patient's hospital stay was not extended, as the patient was discharged on the fifteenth day with a creatinine level at her usual baseline.

- The discharge summary did not include renal failure as a diagnosis, or as “probable, suspected, likely, questionable, possible, or still to be ruled out”; as described in ICD-9-CM Official Guidelines for Coding and Reporting Subsection III (C) Uncertain Diagnosis.
- Adjustments made to the claim as a result of the PRGX audit are supported by the evidence, and the Notice of Recovery of Payments dated August 14, 2014 is valid.

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.
- ✓ A resume documenting the credentials (RHIA, CCS) and experience of the Director of Inpatient Coding.
- ✓ A copy of the ICD-9-CM Official Guidelines for Coding and Reporting.
- ✓ A progress note of the attending physician dated December 7, 2010.
- ✓ A Notice of Findings dated June 18, 2013 explaining the results of an audit supporting the conclusion that an overpayment had been issued.
- ✓ A copy of a Medicaid Provider Agreement and Addendum 1 undated and unsigned.
- ✓ Rhode Island Medicaid Rules and Regulations #0301.20 promulgated on July 21, 2014.
- ✓ Rhode Island Medicaid Rules and Regulations #0300.40.15 effective between September 1, 2010 and March 15, 2012.
- ✓ A copy of Rhode Island General Law, GL 40-8.2-3.
- ✓ Agreement between the parties regarding the agency’s February 19, 2015 submission of evidence.
- ✓ Patient medical records documenting the hospital admission for November 24, 2010 to December 8, 2010.
- ✓ Hearing testimony.

In this matter, the appellant’s representative has argued that appropriate procedure was followed when coding a secondary diagnosis of acute renal failure (AKI) 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).

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 details provided by the treating physician(s). Justifying the existence of a secondary condition warranting coding would depend upon complete and consistent documentation of a treatment method that was sustained throughout the medical record, and/or included in the medical care summary at the time of discharge. Documentation of AKI on December 7, 2010 (day 14 of a 15-day admission) without any further mention of the condition before or after that date is not a well-supported recording of clinical information as emphasized within the guidelines. The lack of subjective findings that would support AKI as a secondary diagnosis or complicating condition has understandably resulted in a difference of opinion between the provider and the agency regarding interpretation of that single entry.

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. The complete record is reviewed for evidence supporting additional efforts to monitor or evaluate characteristics of AKI as a complicating condition, and for proof of specific effects on patient treatment throughout the duration of the entire admission.

The patient was admitted for fever and altered mental state secondary to metastatic brain disease, and a urinary tract infection (UTI). Records documented a history of endometrial carcinoma, heart disease, stroke, diabetes, chronic obstructive pulmonary disease, and morbid obesity. She had been hospitalized for fourteen days before the renal condition was mentioned in the progress notes. Creatinine levels tested routinely had been stable throughout her admission. The single slightly elevated reading taken on December 7, 2010

was documented with a note indicating that it could be monitored the next morning. There is no mention of testing or evaluation, or support by medical history or other treating sources for any genito-urinary system diagnosis other than the UTI that had been treated throughout her hospital stay. There is no indication of previous history of renal disease which would require monitoring as an existing condition.

Although routine laboratory tests identical to those performed on the previous days had been completed on December 8, the effort does not appear to indicate that a clinical evaluation or diagnostic procedure focused on diagnosing AKI was completed. Her creatinine level on that date had returned to her baseline level. No therapeutic treatment, continued monitoring, or increased nursing care was required or indicated. Clearly, renal impairment did not extend the length of her hospital stay, as she was discharged on December 8, 2010.

Subsection III (C) Uncertain Diagnosis indicates:

*"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, arrangement for further workup or observation, and initial therapeutic approach that correspond most closely to the established diagnosis."*

At the time of discharge, fourteen different diagnoses were itemized including those that were "questionable" and those requiring further observation. Neither acute renal failure nor renal insufficiency was mentioned among the discharge diagnoses, addressed among prescribed treatments, or discussed in the follow-up recommendations or continuity of care summary.

Although monitoring may be accepted as a treatment equivalent for the purpose of coding, there is no indication that monitoring insures that a certain diagnosis will be reached. It is very difficult to find anything in this record that even suggests that monitoring was carried out. The physician's clinical notes neither established the existence of a renal impairment, nor expressed further need to rule out the condition.

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.”

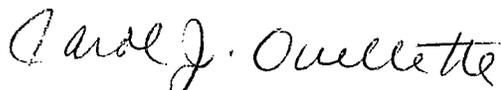
DHS regulation 0300.40.15 indicates that sanctions may be imposed by the agency against a provider for presenting for payment, an inaccurate claim for medical services. A finding was made by the agency’s recovery audit contractor (RAC) that a discrepancy existed between the coding of services rendered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

A review of the available evidence has revealed that the patient’s medical history did not include renal impairment. Although there was one of fifteen creatinine tests that appeared slightly elevated, that occurrence does not sufficiently support the establishment of an additional diagnosis as described by the ICD-9-CM Official Guidelines for Coding and Reporting. At the time of discharge it was not even mentioned as a probable or questionable diagnosis to be further monitored, evaluated or ruled out.

As coding of medical records may be performed for a variety of reasons, the coder may have found other justification for coding the particular entry without querying the physician for further clarification. This Appeals Officer is aware of the fact that coders are often guided by additional written directives which provide more information about coding under circumstances that are unique or less common than most. No supplemental guidelines have been cited or submitted as evidence other than the sections of the ICD-9-CM itemized above. If hospital rules require coding of certain entries for statistical or other purposes, then the Medicaid Administrator has justifiably expressed concerns regarding the resulting financial impact on the Medicaid program. Relying upon certain coding practices as a basis for billing of patient care could capture fees for services that do not accurately represent the care provided to the RIMAP beneficiary.

After careful and considerate review of the regulations and guidelines, as well as the evidence and testimony submitted, this Appeals Officer concludes that the agency has recalculated the payment appropriately based on the care provided to the Medicaid recipient in this case, as supported by the medical evidence records and applicable guidelines.

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

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 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.

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.