



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 # 15-188

[REDACTED]
Hearing Date: February 12, 2015

Date: May 26, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided in your favor upon a de novo 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: J [REDACTED]

[REDACTED] 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 Contractor (RAC) program is federally mandated.
- As a state that provides Medicaid, Rhode Island chose PRGX as a RAC provider 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.
- PRGX has reviewed inpatient claims from Rhode Island Hospital.
- 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 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, 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.
- After considering the explanation that the hospital coded AKI (acute renal failure) based on a "question", and without establishing that it actually existed, and without providing treatment; he does not believe that Medicaid should have paid for the coded service that was never provided.
- While he understood that the coder felt obligated to code the condition, he did not believe that the coding decision should result in the Medicaid program's responsibility to pay for it.
- Medicaid should not be responsible to pay, as the patient was never diagnosed or treated (for AKI) during the admission.
- The medical record does not support the service.
- Laboratory tests are considered diagnostic tools, and do not qualify as treatment.

- Although there was a question of acute renal failure which they considered, they never diagnosed the condition, as evidenced by the fact that they did not treat it.
- If the service was never provided, according to federal laws and statutes, Medicaid is not obligated to pay for it.
- The coder's commitment to following CMS guidelines for coding does not guarantee that the diagnosis actually existed, or that the patient was ever treated for the condition in question.
- As administrator of program integrity he is responsible to look for fraud, waste, and abuse.
- An improper payment involves paying for service that was never provided, which is what he believes happened in this case.
- EOHHS is required to follow federal regulations under 42 CFR455.
- Coding is dependent upon the clinical findings, which must be considered for the purpose of resolving this appeal.

The PRGX Chief Medical Director testified for the Agency:

- She is a medical doctor, and 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.
- Jeffrey Harding, a CPC (Certified Professional Coder), was also available to testify.
- She would lead the presentation of the testimony, and Mr. Harding could add information as needed.
- The patient is an 88- year-old female who was admitted with shortness of breath, dyspnea, and coughing.
- She had a history of high blood pressure (Htn), atrial fibrillation (AFib), and diastolic congestive heart failure (CHF).

- The patient was treated with antibiotics for pneumonia, and was given diuretics as part of her treatment for congestive heart failure.
- In this case, the provider coded ICD-9 code 584.9, which denotes acute renal failure, as an additional complicating diagnosis.
- A review of the medical record does not support the assignment of code 584.9.
- In order to assign this code, the entire medical record should be used to determine if the appropriate diagnosis and procedure were identified.
- While there was a question that the patient may have renal insufficiency, there was no definite diagnosis made.
- The progress notes, and discharge summary do not document chronic renal insufficiency.
- There is no evidence that the patient had acute renal failure which would indicate that the patient's kidney function had deteriorated during the hospital admission.
- If that had been the case, the deterioration of renal function would have been diagnosed as having been present in addition to her other medical problems.
- The admitting diagnoses in this case were congestive heart failure and pneumonia.
- The patient was specifically treated for the conditions diagnosed (CHF and pneumonia) with antibiotics and Lasix.
- The discharge diagnoses also included diastolic CHF, and pneumonia as well as chronic AFib.
- It was noted within the objective evidence that creatinine was tested as measure of renal function.
- Her creatinine level upon admission was 1.86, and at discharge it was at 2.11.
- During the course of her hospitalization, renal function deteriorated, which is not uncommon with the use of Lasix.
- She left the hospital with less renal function than when she arrived.

- Acute renal failure was not a presenting diagnosis during the course of her hospitalization.
- Therefore, acute renal failure should not be coded in this case.
- The conclusion is consistent with ICD Official Guidelines 2011 section III.
- That section states that the entire medical record must support the diagnosis for additional codes.
- After reviewing the progress notes in order to verify the appellant's claim that AKI was actually diagnosed and documented, she maintains that the hospital physician noted that there was a "question" of AKI, and that patient self-report included AKI medical history, but there was no established diagnosis.
- The patient arrived with a creatinine level of 1.86 and left with 2.11, and there was no evidence that the physicians were concerned about AKI after seeing creatinine levels rising at discharge.
- In order for a secondary diagnosis to be coded, that diagnosis must first be established, then it must be treated and addressed.
- In this matter the diagnosis was never established, treated or addressed.
- The patient was admitted for congestive heart failure and was given diuretics.
- By necessity, they were required to monitor kidney function while diuresing the patient.
- They were ordering tests for a completely different reason other than renal insufficiency.
- The admitting diagnoses and the discharge diagnoses were exactly the same.
- They never treated her for acute renal insufficiency, because her renal insufficiency was getting worse.
- With targeted treatment for renal insufficiency it would have been getting better.
- The patient's underlying renal insufficiency is her baseline, which therefore, makes it inappropriate to code it as a secondary diagnosis.

- The clinical evidence in this case does not support the coding guidelines with respect to coding of AKI as a secondary diagnosis.
- The medical record does not support that the diagnosis was established, treated or addressed; therefore the appellant representatives are arguing clinical findings in this matter, and not procedures to be coded.

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 a credential given for mastery of patient coding by the American Health Information Management Association which she earned 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.
- The disagreement lies with the coding of the secondary diagnosis of acute renal failure.
- There is no issue with the coding of congestive heart failure as the principle diagnosis, as both parties are in agreement.
- The auditor is recommending that the hospital coder delete the code for acute renal failure.
- When they have a diagnosis in the record which is clinically supported, coders would not challenge the doctor's practice of medicine.
- They are required to code the diagnosis.

- According to the Official Coding Guidelines provided by CMS (Center for Medicare and Medicaid Services), they assert that by coding the secondary diagnosis, the rules have been followed correctly.
- The auditor asking them to delete the code stating that, "While there was a question if the patient has AKI (acute renal failure), there was no definitive diagnosis made."
- The auditor's statement displays a lack of knowledge of coding regulations.
- The records include two references to acute renal failure in progress notes of October 30 and October 31.
- If that is the doctor's final diagnosis, they are required to code that.
- As clinical support for that code, they found that the patient had abnormal lab results.
- There was a creatinine level taken in the middle of the admission of 2.26 which supports acute renal failure.
- Deleting the code would be against regulations, and could be considered fraudulent.
- They did code statements indicating that there was a "question" of AKI because they are required to code as if the condition existed regardless of whether or not a definitive diagnosis had been reached, according to the coding regulations.
- The coding guidelines define what is considered to be treatable and reportable.
- A secondary diagnosis would qualify if it had been clinically evaluated, required any therapeutic treatment, or involved diagnostic procedures that extended the length of stay, or that increased nursing care, handling, or if monitoring was necessary.
- AKI was considered treated, as labs tests were ordered in an effort to monitor the condition.
- There is a coding guideline that indicates if conditions are labelled possible, probable, question of, or suspected, they are required to code them.

- Because the doctor wrote about the condition in the medical record, it is considered addressed, diagnosed, and treated.
- Ordering of multiple lab tests to monitor the renal failure demonstrates treatment of the condition of renal failure.
- Monitoring and evaluating are equivalent to treating for coding purposes.
- Because the coders review an enormous number of medical records, it is imperative that they have very specific, uniform guidelines in place to follow.
- Instructing them not to code conditions that appear to be untreated would be too vague, which is why guidelines include more exact characteristics they must look for.

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 called for 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 information.
- 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, complete medical records of the patient's hospital admission for October 29, 2010 to November 5, 2010 were submitted by the appellant, and made part of the evidence record.
- The new records also incorporated a discharge summary from another hospital for an earlier admission of September 17, 2010 through September 27, 2010 was is not a factor relative to accuracy of payment..
- Evidence established that the patient's medical history of chronic renal insufficiency (AKI) was communicated to hospital staff upon admission for congestive heart failure (CHF) and pneumonia.
- Verification of the coexisting diagnosis was established by two additional treating sources.
- The hospital progress notes were changed from an indication that there was a question of a renal insufficiency to reflect a confirmed history of the disorder.
- Creatinine levels were monitored by medical staff as part of her care for CHF with knowledge of her underlying AKI, and of her baseline levels.
- Laboratory tests revealed a predictable increase in creatinine levels while using diuretics.
- Renal impairment was also indicated by results of a CT scan.

- The hospital records documented the renal condition as an “active medical problem” on a Continuity of Care form on the date of discharge.
- The ICD-9-CM coding guidelines define “other diagnoses” as additional conditions that affect patient care.
- The ICD-9-CM coding guidelines allow historical medical conditions that impact patient care to be coded as a secondary diagnosis.
- The guidelines establish that, in this matter, a secondary diagnosis of acute renal failure (AKI) was established and addressed, and therefore, appropriately coded according to the ICD-9-CM Official Guidelines for Coding and Reporting.

DISCUSSION OF THE 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.
- ✓ Partial medical records of the patient associated with this case including a progress note dated October 31, 2010, as well as laboratory test results for October 29, 2010 to November 4, 2010 (3 pages).
- ✓ 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 representing the hospital admission for October 29, 2010 to November 5, 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 the medical records in this case is not as ideally complete and consistent as emphasized within the guidelines, which has understandably resulted in a difference between the provider and the agency regarding interpretation of some of the entries or omissions.

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. While the word "treatment" typically suggests an active, targeted attempt to cure a condition, the guidelines have established that a variety of other types of care become the equivalent of treatment for the purpose of establishing and coding additional diagnoses. For the rationale of this decision, consideration is given to the broader definition established by CMS within the coding guidelines, allowing for attention to various efforts to monitor or evaluate characteristics of a suspected condition, and recognize the significance of that action throughout the overall treatment regimen.

The patient medical records of her admission for congestive heart failure also reveal certain facts regarding her renal impairment. The history of the coexisting condition was reported upon admission, and again by her daughter on October 31, 2010. The hospital staff took measures to obtain prior hospital records, as well as specific information relative to chronic renal insufficiency from her primary care physician. They were able to verify the diagnosis, learn what the patient's baseline renal function would typically look like, and establish that the condition was chronic (of significant duration, and requiring ongoing treatment) when they obtained the medical history.

The October 31, 2010 physician notes indicated a question of acute renal failure (AKI) based on patient report of medical history at intake. Subsequent progress notes reflected the replacement of the entry "question of" (denoted by a ?) AKI appearing within the "Assessment Plan" section of the records with a more definitive diagnosis of CRI (chronic renal insufficiency), and also documented the patient's baseline creatinine level range of 1.8-1.9 as provided by her PCP. Obtaining medical information changed the questionable condition from a probability, question, suspicion, likeliness or possibility to a confirmed diagnosis by history. Although the condition may have been improved or stabilized during the prior hospitalization, a diagnosis of chronic CRI is not a condition that would have been expected to have been totally resolved and could be disregarded.

It is clear that the October 2010 admission was for a primary diagnosis of congestive heart failure, and the diuresis was ordered for that reason. However, as the progress notes of record had been changed to reflect that verification of longitudinal renal insufficiency has been a factor, the attending medical staff would have been informed of the need to monitor the impact of the diuresis ordered to manage CHF on the underlying condition. Renal function was tested daily throughout her hospital stay. Laboratory test results including daily measures of creatinine levels were submitted as evidence. Five readings taken from October 31, 2010 through November 4, 2010 were detailed. It would seem logical that responsible attending physician(s) would want to monitor creatinine levels for both reasons. Following confirmation of the diagnosis, the laboratory tests originally ordered to treat the primary CHF condition inevitably would serve a dual purpose.

Although the renal condition appeared to be worsening somewhat during the hospital admission, (as is commonly the case during diuresis); the treating physician had already obtained the background information, and had knowledge of the underlying condition. Results would allow the physician to determine whether or not any further action was required based on the patient's already elevated baseline information. While additional workups and treatments were not ordered, it is believable that those decisions were made possible based on the average function of the particular patient, rather than ideal textbook creatinine levels.

Subsection III Reporting Additional Diagnoses

A) Previous conditions (paragraph 2):

"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. Although the renal impairment did not appear in the discharge diagnosis list, it was indicated as part of the history of present illness, and was included in the Continuity of Care at discharge, not as an uncertain diagnosis, but as an “Other active medical problem.”

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 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 including her chronic renal insufficiency was communicated to the provider upon admission, and was verified by her PCP and attending medical staff from a prior admission to another hospital. The diagnosis was accepted, as records were changed to reflect monitoring of a previously diagnosed, but unresolved secondary condition rather than a condition that remained probable or questionable. Renal impairment was also supported by results of a left lower quadrant CT scan completed on October 29, 2010, which revealed "mild cortical thinning of the left kidney". Additionally, the condition was noted as an "active medical problem" on a Continuity of Care" form on the date of discharge, November 5, 2010. While Lasix treatment was prescribed for CHF, it was administered and monitored with physician knowledge and consideration of the renal insufficiency. The CMS guidelines establish that the care given in this matter would be equivalent to treatment.

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. Appropriate procedure was followed when coding a secondary diagnosis of acute renal failure (AKI) according to the rules established by the ICD-9-CM Official Guidelines for Coding and Reporting.

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 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 Worker's 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.