Advocating for Quality Documentation and Adherence to Official Coding Guidelines

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Background

In August 1996, the Health Insurance Portability and Accountability Act (HIPAA) [Public Law 104-191] established the infrastructure and funding for federal fraud and abuse efforts. This legislation authorizes the appropriation of $104 million in 1997, with increases in 15 percent increments until 2003, to defray the costs of the Department of Health and Human Services (HHS) Office of Inspector General's (OIG's) and the Federal Bureau of Investigation's enforcement activities. Section 201(b) establishes the Health Care Fraud and Abuse Control Account within the Medicare Trust Fund. Under the legislation, this account will receive proceeds from: 1) criminal fines from "federal health care offenses"; 2) civil money penalties from cases involving Medicare and Medicaid or the peer review provisions; 3) forfeitures of property arising from federal healthcare offenses; and 4) penalties and damages obtained from health-related False Claims Act actions.

Section 201 of HIPAA also creates the Fraud and Abuse Control Program, through which Congress grants the OIG and the US Attorney General joint authority to coordinate federal, state, and local law enforcement programs to control all healthcare fraud and abuse. Section 203 mandates the creation of a program to encourage individuals to report suspected fraud and abuse violations. The Secretary of HHS is directed to establish a program for encouraging individuals to report persons who are, or have been, engaged in any activity that constitutes fraud and abuse against Medicare.

Sections 241 through 250 of HIPAA revise the federal criminal law to provide for a federal healthcare offense relating to a healthcare benefit program. The definition of healthcare benefit program includes federal healthcare programs and "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract." HIPAA establishes new criminal provisions covering a wide range of activities: healthcare fraud, theft, or embezzlement in connection with healthcare; false statements relating to healthcare matters; obstruction of criminal investigations of healthcare offenses; and laundering of monetary instruments related to a federal healthcare offense.

Section 231 of HIPAA increases the intent standard that the government must meet for civil monetary penalties. To establish liability, the government must demonstrate that the defendant "knowingly" submitted false claims. "Knowingly" is defined so that one may be liable if a false claim or statement is made: 1) with actual knowledge that it is false; 2) in deliberate ignorance of the truth or falsity of the information; or 3) in reckless disregard of the truth or falsity of the information.

In the regulatory arena, OIG expects to complete more than 100 reviews of various healthcare providers, including hospitals, physicians, home health care agencies, clinical labs, and managed care plans to detect whether they are correctly billing the Medicare and Medicaid program for services. The healthcare fraud and abuse initiative, Operation Restore Trust, will add 12 mores states to the five already targeted by the two-year-old program. The program focuses on home health providers, nursing homes, and durable medical equipment suppliers.

During the past several months, the federal government has instituted the second half of its enforcement activities concerning billing under Medicare Part B for physician services performed at teaching hospitals. In 1996, HCFA adopted a variety of standards that teaching hospitals must now meet to bill for physician services under Medicare Part B. More recently, OIG announced that it will conduct audits nationwide to evaluate compliance of teaching hospitals in past years with regulatory requirements.

The healthcare field is highly regulated by a complex statutory and regulatory scheme. HIM professionals, at the crossroads of healthcare and information management, are profoundly impacted by the interpretation and implementation of government policy for reimbursement of institutional and provider claims. HIM professionals are uniquely qualified to provide leadership in

healthcare organizations to ensure that the documentation in the medical record is accurate and appropriate to support the diagnoses and procedures selected for reimbursement.

Resolution

Topic:	Advocating for Quality Documentation and Adherence to Official Coding Guidelines
Intent:	Promote the quality of documentation to support the appropriate use of codes for institutional and provider reimbursement
Addressed to:	All HIM professionals and AHIMA's strategic partners
Approved by:	1997 House of Delegates
Date:	October 19, 1997

Whereas, detection of healthcare fraud and abuse is a major activity at the federal, state, and local areas of government;

Whereas, ever-changing guidelines for reimbursement impact the ability of healthcare organizations to submit appropriate claims;

Whereas, insurers and payers do not uniformly adhere to official coding guidelines;

Whereas, AHIMA and its component organizations encourage healthcare providers, organizations, insurers, and other appropriate parties to adhere to official coding guidelines in submitting institutional and provider claims for reimbursement;

Whereas, AHIMA members promote accurate and ethical coding; therefore, be it

Resolved, That AHIMA members promote accurate and complete documentation that reflects the level of services provided to the patient and ensure that the HIM profession continues to play a pivotal role in addressing fraud and abuse; and

Resolved, That AHIMA and its component organizations advocate that the federal government and insurers adopt nationwide official coding standards and guidelines used in the development and interpretation of policy for institutional reimbursement and provider claims.

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