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## Introduction

This chapter covers how the Health Insurance Portability and Accountability Act of 1996 (HIPAA) dictates the ways in which healthcare providers must handle patients' protected health information (PHI), and the basic structure and legal requirements for medical records.

## Health Insurance Portability and Accountability Act (HIPAA)

Congress enacted HIPAA in 1996 to improve patients' right to and protection of their personal health information. HIPAA also limited exclusions for pre-existing conditions, and prohibited discrimination against employees and dependents based on their health status. HIPAA also established the *Healthcare Fraud and Abuse Control Program* to combat fraud and abuse in both public and private healthcare programs.

HIPAA includes Administrative Simplification provisions, which mandated the U.S. Department of Health and Human Services (HHS) adopt national standards for electronic healthcare transactions and code sets, unique health identifiers, and security of PHI. To that end, HHS published a number of final rules:

- The Privacy Rule was published in December 2000, and later modified in August 2002;
- The Security Rule was published in February 2003; and
- The Omnibus Rule was implemented in 2010.

## Electronic Healthcare Transactions

HIPAA regulations standardized transactions for the Electronic Data Interchange (EDI) of PHI. Under HIPAA, electronic transactions must adhere to the content and format requirements of ASC X12N or NCPDP (used for certain pharmacy transactions).

Electronic transactions include: claims and encounter information, payment and remittance advice, claims status, eligibility, enrollment and disenrollment, referrals and authorizations, coordination of benefits, and premium payment.

Code sets include: Healthcare Common Procedure Coding System (HCPCS) Level II codes for ancillary services and supplies; Current Procedural Terminology (CPT®) codes for professional services; Current Dental Terminology (CDT®)

codes for dental procedures; International Classification of Diseases-10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) codes for diagnosis; International Classification of Diseases 10<sup>th</sup> Revision Procedure Coding System for inpatient hospital procedures and National Drug Codes (NCD).

Unique identifiers for employers include Tax Identification Numbers (TINs) and for providers National Provider Identifiers (NPIs).

## Protected Health Information (PHI)

PHI is "individually identifiable health information." Common identifiers include demographic data, name, address, birth date, and Social Security number. Information that relates to an individual's past, present, or future physical or mental health is also protected; as is the provision of healthcare to the individual or the past, present, or future payment for the provision of healthcare to the individual, which reasonably may be used to identify the individual.

There are no restrictions on the use of de-identified health information. When PHI is removed from the medical record, a reasonable basis does not exist to identify an individual.

## Privacy Rule

HIPAA Privacy Rule standards address how covered entities and their business associates may handle PHI (electronic or otherwise). Effective April 14, 2004, all "covered entities" and "business associates" must comply with the Privacy Rule.

*Covered entities* are defined in the Privacy Rule as any of the following:

- **Health Plan** covered entities pay providers on behalf of an individual receiving medical care. These plans include health, dental, vision, and prescription drug insurers. Examples include health maintenance organizations (HMOs), Medicare, Medicaid, and Medicare supplement insurers, and employer-, government-, and church-sponsored group health plans. An employer who solely establishes and maintains the plan with fewer than 50 participants is exempt. Two types of government-funded programs are not health plans: food stamps and community health centers. Insurers providing only workers' compensation, automobile insurance, and property and casualty insurance are not considered to be health plans.
- **Healthcare providers** who electronically transmit health information through certain transactions are

## Provider Options - RAC Overpayment Determination

	Discussion Period	Rebuttal	Redetermination
<b>Which option should I use?</b>	The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period.	The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment action will cause a financial hardship and should not take place. A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal should not duplicate the redetermination process. (See 42 CFR 405.374-375)	A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on day 41.
<b>Who do I contact?</b>	Recovery Audit Contractor (RAC)	Claim Processing Contractor	Claim Processing Contractor
<b>Timeframe</b>	Day 1 - 30	Day 1-15	Day 1-120 Must be submitted within 120 days of receipt of demand letter. To prevent offset on day 41 the Redetermination must be filed within 30 days.
<b>Timeframe Begins</b>	Automated Review: Upon receipt of the Initial Findings Letter (IFL) Complex Review: Upon receipt of Review Results Letter	Date of Demand Letter	Upon receipt of Demand Letter
<b>Timeframe Ends</b>	Day 30 (offset begins on day 41)	Day 15	Day 120

The table below shows recoveries by RACs by fiscal year and by corrections made to the FFS providers.



### Medicare Fee-for-Service Recovery Audit Program

#### Total Corrections\* - by Fiscal Year (FY\*\*)

	FY 2010 (in Millions)	FY 2011 (in Millions)	FY 2012 (in Millions)	FY 2013 (in Millions)	FY 2014 (in Millions)	FY 2015* (in Millions)	National Program (in Billions)
<b>Overpayments Collected</b>	\$75.4	\$797.4	\$2,291.4	\$3,650.9	\$2,394.8	\$359.7	\$9.5696
<b>Underpayments Returned</b>	\$16.9	\$141.9	\$109.4	\$102.4	\$173.1	\$81.0	\$0.6247
<b>Total Corrections</b>	\$92.3	\$939.3	\$2,400.8	\$3,753.3	\$2,567.9	\$440.7	\$10.2006

CMS offers the following advice to prepare providers for payer audits:

1. Know where previous improper payments have been found. Look to see what improper payments were found by OIG and contracted payers.
2. Know if you are submitting claims with improper payments. Conduct an internal assessment to identify if you are in compliance with Medicare rules and identify corrective actions.
3. Appeal when necessary. The appeal process for many payers is the same as the appeal process for MAC denials.

CDEO's should check payers' websites for issues currently being reviewed, and should review past improper payments found. Auditors may use this information to target reviews to help providers determine if they are in compliance.

## Physician Queries

A physician query clarifies conflicting, ambiguous, or incomplete information about significant conditions, procedures, or reasons for tests in the medical record of the patient. A query is not intended to introduce new information the provider may have not considered. The query also may serve as an educational tool to improve physician documentation and the coders' understanding of clinical scenarios. Queries may also be required to determine the correct code for a diagnosis or procedure, or to clarify if a causal relationship exists between two diagnosis.

Queries may be done while the patient is still an inpatient in the hospital, or prior to leaving the physician's office to allow the physician an opportunity to clarify a diagnosis or procedure prior to the patient's departure. These are called concurrent reviews and queries. A query conducted after the patient has left is called a retrospective query. The facilities' processes should include a way to record the queries, such as an electronic database, or inclusion of the query in the medical record. The query should include:

- Patient name
- Admission date and/or date of service
- Health record number
- Account number
- Date query initiated
- Name and contact information of the individual initiating the query
- Statement of the issue in the form of a question along with clinical indicators specified from the chart

The query should not be constructed in a manner that can be interpreted as leading the physician. Queries can be open, and provide documentation from the medical record, along with

clinical documentation to obtain and a more concise diagnosis from the physician. Multiple choice or yes/no queries may be used; however, it is important when providing choices for physicians to include the option of other, or if the diagnosis was uncertain, or could not be determined.

### SAMPLE QUERY TEMPLATES

#### Diabetes Mellitus and Complication Not Tied Together

"This patient has diabetes mellitus and hyperlipidemia. Please addend the visit note dated xx/xx/xx to document the relationship, if any, between the diabetes and the hyperlipidemia. Thank you."

#### Contradictory Visit Note

"There is contradictory information in the visit note. Documentation in the respiratory section of the note states the patient does not have any respiratory diagnoses, yet the Assessment states the patient does have COPD. If the patient does have COPD, please addend the visit note. If the patient does not have COPD, please remove the diagnosis. Thank you."

"There is contradictory information in the visit note. Documentation in the Social History section of the note indicates the patient has never smoked, yet the Assessment states the patient has chronic bronchitis due to smoking. Please addend the visit note to resolve the contradiction. Thank you."

#### Abnormal Findings

Often there are clinical indicators within the note itself.

"Foot exam indicates abnormal findings of reduced sensation found on monofilament test and reduced vibration sense. Is there a resulting diagnosis for these clinical findings? If yes, please addend the visit note with any resulting diagnosis. Thank you."

#### Test Results Not Added to Visit Note

"Ultrasound ordered from office visit xx/xx/xx indicates atherosclerosis of extremity. If you agree with this diagnosis, please addend the visit note dated xx/xx/xx with the test findings and resulting diagnosis. Thank you."

#### Cancer

Cancer that has been excised is always a problem area, especially with primary care providers.

"On xx/xx/xx active cancer was listed in the Assessment. If the patient is on active treatment such as adjunct treatment, please addend the visit with the status and management. If the patient has completed treatment and is no longer on active or adjunct treatment, please addend the visit with the history of diagnosis. Thank you."

Source: Barton, D. (2017, March 09). Query Physicians to Improve Documentation and Dx Coding. Retrieved from <https://www.aapc.com/blog/37864-query-physicians-to-improve-documentation-and-dx-coding/>



## EXAMPLE

A patient 16 weeks pregnant with triplets comes to the office for her routine OB appointment.

O30.102 Triplet pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, second trimester

Z3A.16 16 weeks gestation of pregnancy

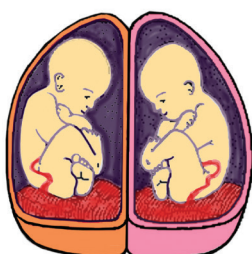
## EXAMPLE

A woman at 32 weeks gestation presents with threatened preterm labor. She is admitted and given tocolytic drugs.

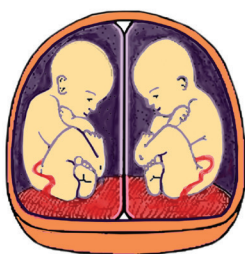
O47.03 False labor before 37 completed weeks of gestation, third trimester

Z3A.32 32 weeks gestation of pregnancy

### Placental and Amniotic Differences in Twin Gestations



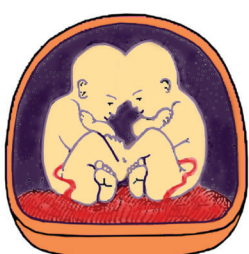
Dichorionic/Diamniotic



Monochorionic/Diamniotic



Monochorionic/Monoamniotic



Conjoined Twins

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### Threatened Preterm Labor

Threatened preterm labor is the presence of uterine contractions of sufficient frequency and intensity to effect progressive effacement and dilation of the cervix prior to term gestation (between 20 and 37 weeks). Documentation must include the trimester of the pregnancy. An additional code from category Z3A identifies the number of weeks of gestation. Codes for threatened preterm labor are:

O47.00 False labor before 37 completed weeks of gestation, unspecified trimester

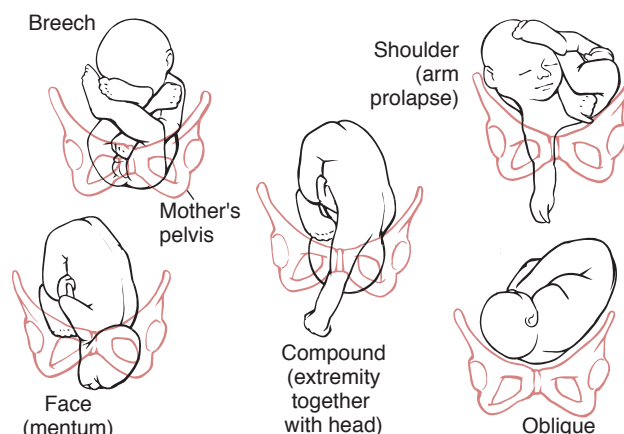
O47.02 False labor before 37 completed weeks of gestation, second trimester

O47.03 False labor before 37 completed weeks of gestation, third trimester

### Delivery

When a delivery occurs, select the principal code based on the circumstances of the delivery. Codes are categorized by type (cesarean, breech, normal) and complications (e.g., arrested inertia, malposition, preeclampsia, diabetes, hemorrhage, failed induction, laceration).

When a delivery involves multiple complications, select a code for each complication. In some categories, the trimester of the pregnancy will need to be indicated. An additional code from Z3A is reported to indicate the weeks of gestation. A code from category Z37 Outcome of delivery should be reported on the maternal chart, only.



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The options under the category for outcome of delivery include:

- Single Live Birth
- Single Stillbirth
- Twins, both liveborn
- Twins, one liveborn and one stillborn
- Twins, both stillborn
- Other Multiple Births, all liveborn
  - Triplets
  - Quadruplets



- Sextuplets
  - Other multiple births
- Other Multiple Births, some liveborn
  - Triplets
  - Quadruplets
  - Sextuplets
- Other multiple births
  - Other multiple birth, all stillborn

When a delivery involves multiple complications, select a code for each complication. When an episode of care does not result in a delivery, report the complication causing the patient to be seen.

Per guideline I.C.15.n.1, assign O80 *Encounter for full-term uncomplicated delivery* when a woman is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode. Code O80 is always a principal diagnosis. Do not use if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or perinatal period. Just because a patient had an issue during the pregnancy, does not negate the use of the normal delivery code. Guideline I.C.15.n.2 states that O80 may be used if the patient had a complication at some point during the pregnancy, but the complication is not present at the time of admission for delivery.

#### EXAMPLE

A pregnant patient delivers twins at 30 weeks gestation. Fetus 1 is delivered vaginally. During the delivery, fetus 2 turned into the transverse position during labor. The decision is made to perform a cesarean to deliver the second baby.

O32.2XX2 Maternal care for transverse and oblique lie, fetus 2

O60.14X1 Preterm labor third trimester with preterm delivery, third trimester, fetus 1

O60.14X2 Preterm labor third trimester with preterm delivery, third trimester, fetus 2

O30.003 Twin pregnancy, unspecified number of placenta and unspecified number of amniotic sacs, third trimester

Z3A.30 30 weeks of gestation of pregnancy

Z37.2 Twins, both liveborn

## Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)

For coding and reporting, the perinatal period is defined as immediately before birth through day 28 following birth. ICD-10-CM Official Guidelines for Coding and Reporting for this chapter include:

- **General Perinatal Rule:** All clinically significant conditions noted on routine newborn exam should be coded. A condition is clinically significant if it requires clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and monitoring, or has implications for future healthcare needs. Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient's age.
- **When coding the birth of an infant,** assign a code from category Z38 according to the type of birth. A code from this series is assigned as a principal diagnosis and assigned only once to a newborn at the time of birth. If the newborn is transferred to another facility, a code from category Z38 is not used by the receiving hospital. If the newborn is observed for a suspected condition that is not found, code Z05 is reported secondarily to a code from category Z38. Code Z05 is only reported for healthy newborns and infants for which no condition, after study, is found to be present. Code Z05 may be assigned as a principal or first-listed diagnosis when the code from category Z38 is no longer applicable.
- **Prematurity and Fetal Growth Retardation:** Codes from categories P05 *Disorders of newborn related to slow fetal growth and fetal malnutrition* and P07 *Disorders of newborn related to short gestation and low birth weight, NEC* should not be assigned based solely on recorded birth weight or estimated gestational age, but on the attending physician's clinical assessment of maturity of the infant. Because physicians may utilize different criteria in determining prematurity, do not code the diagnosis of prematurity unless the physician documents this condition. When both birth weight and gestational age are available, the code for the birth weight is sequenced before the code for gestational age.

#### EXAMPLE

An infant develops a cold and later develops convulsions, originating during the perinatal period. This condition would be coded with ICD-10-CM code P90 *Convulsions of newborn*.

Look in the ICD-10-CM Alphabetic Index for Convulsions/newborn. Verify the code in the Tabular List.