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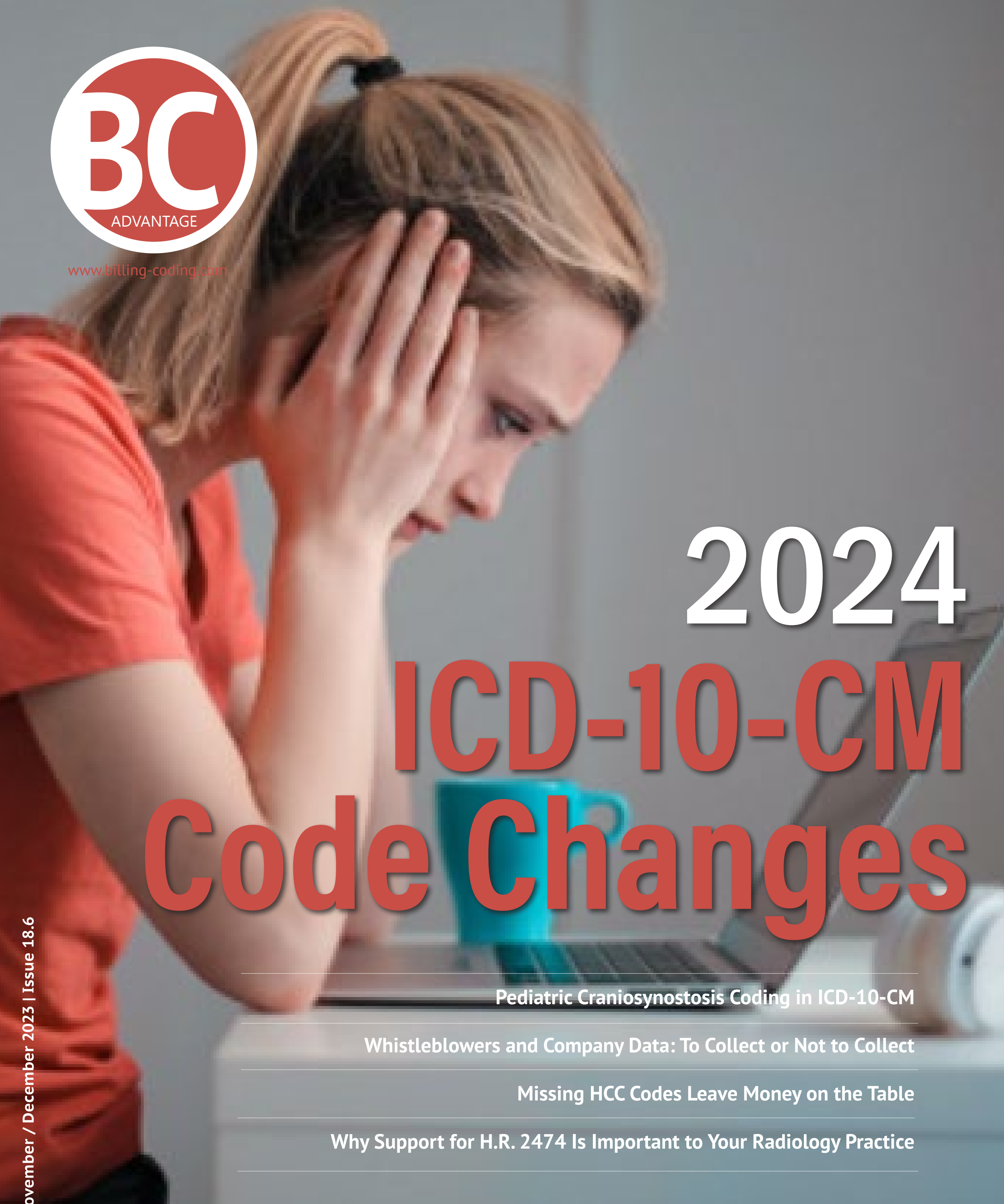

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CEO Letter

As we head into the last months of 2023, I cannot help but wonder what 2024 will bring. We have seen some great highs and horrific lows this year. As I write this, there are many tragedies unfolding all over the world, bringing us into what seems to be total chaos. It is at times like these that I make sure to surround myself with those I love and look for the positives in my life. I wish you all the happiest end to the year and for peace on earth. Seriously.

So, with a new year come new codes. Betty A. Hovey, BSHAM, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, from Compliant Health Care Solutions provides a great rundown of the ICD changes for 2024. Debbie Jones, CPC, CCA, from Medical Coding Buff presents an extensive article discussing pediatric craniosynostosis coding. It's an interesting piece that provides a wealth of information about a complex condition that personally, I had not heard of before. I learned a lot and hope you do, too.

The AIHC volunteer committee offers an excellent article on telebehavioral health that we've included. If you need more information on psychiatric compliance, they also offer an online coding and documentation course that is reasonably priced and very comprehensive. Go to their website to learn more.

For those of you who are in radiology, Sandy Coffta from Healthcare Administrative Partners discusses the importance of supporting H.R. 2474. Be sure to read how it affects you and your practice. Randi Tapio, MBA, CMRS, CPCS, CHM, CHBP, and her team from MedCycle Solutions talk about prior authorizations and how to decode the maze. Rachel Rose, JD, MBA, shares another great piece this issue, and this one is about whistleblowers and company data. She has also recorded new webinars for our members (one on AI and another on the False Claims Act), so keep an eye out for those! We'll let you know once we have them approved for CEUs. David Jakielo is back with his thoughts on the American healthcare system, and Sonal Patel excerpts more fraud, waste, and abuse cases.

As always, it is an interesting issue full of different topics and information.

Until next time,

Storm

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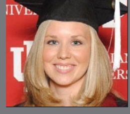

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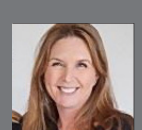

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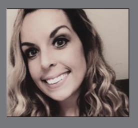

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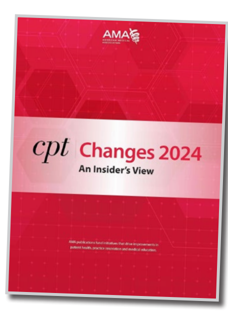

EXPERT Contributors this issue

The American Healthcare Institute of Healthcare Compliance (AIHC) is a 503(c)(3) organization and an internationally recognized leader in healthcare compliance training and certification. Learn more about the AIHC Psychiatric Compliance - Short Course in Documentation and Coding at: https://aihc-assn.org/courses/psychiatric-compliance-a-short-course-in-documentation-and-coding/.

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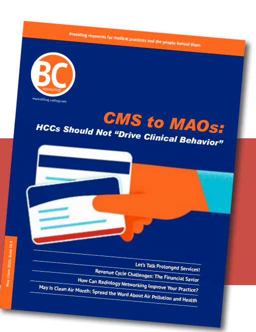

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349 Ways CPT Codes Set Prepares Physicians for Practicing in 2024

The CPT code set, which describes 11,163 medical services and procedures, keeps evolving to match the rapid pace of innovation in medical science and health technology. The annual update includes 349 editorial changes—including 230 additions, 49 deletions, and 70 revisions.

One important change involves the consolidation of more than 50 previous codes to streamline reporting of immunizations for COVID-19. Also, a new vaccine-administration code, 90480, was approved for reporting the administration of any COVID-19 vaccine for any patient. This replaces all previously approved, product-specific vaccine-administration codes.

Other additions respond to product-specific innovations in the prevention of respiratory syncytial virus (RSV). Five new CPT codes have been created to report product-specific RSV immunizations: 90380, 90381, 90683, 90679, and 90678. These codes will provide better tracking to support data-driven planning and allocation.

Clarifications sought by the Centers for Medicare & Medicaid Services (CMS) prompted revisions to the code set that clarify reporting of evaluation and management (E/M) services.

They include:

- Removal of time ranges from office or other outpatient-visit codes 99202–99205 and 99212–99215 and aligned the format with other E/M codes.
- A definition to determine the “substantive portion” of a split or shared E/M visit in which a physician and a nonphysician health professional work together to furnish work related to the visit.
- Instructions for reporting hospital inpatient or observation services and admission and discharge services for the use of codes 99234–99236 when the patient stay crosses over two calendar dates.

Changes to the code set are considered through an open process managed by the AMA CPT Editorial Panel, an independent body convened by the AMA to ensure CPT content reflects the coding and data-driven demands of a modern healthcare system including digital health and augmented intelligence (AI), often called artificial intelligence.

Source: AMA

Fort Worth Mom Earns Degree While Battling Stage 4 Breast Cancer

Ariella Scott, 26, stood anxiously on the side of the stage at Charles F. Dodge City Center in Pembroke Pines, Florida, on Sept. 8 — waiting for her name to be called.

In just a few minutes, she would be receiving her Associate of Science in medical billing and coding from Keiser University.

For the past three years, Scott had been completing her college courses online from her home in Fort Worth. The commencement ceremony marked the first time she’d been to an in-person school event in Florida.

One by one, Scott’s class members walked the stage to receive their degrees.

Finally, she heard her name — Scott walked across the stage with a smile.

From the audience, Scott’s 4-year-old daughter, Alleira, and her mother, Celines Santiago, cheered her on.

Source: fortworthreport

Physician, Two Pharmacists Charged in $170M HealthCare Fraud, Kickback, and Money Laundering Scheme

Pharmacist Shalondria Simpson, 45; physician Lashondria Simpson-Camp, 45; and pharmacist Shayla Bryant, 38, are accused of conspiring to submit fraudulent claims between 2016 and 2022.

Simpson owned and operated two pharmacies in Houston, while her twin sister Simpson-Camp would allegedly refer prescriptions to those pharmacies in exchange for illegal kickbacks and bribes.

Officials said the three would submit the claims to the Department of Labor’s Office of Workers’ Compensation Program (DOL-OWCP) for high reimbursing drugs that were often medically unnecessary and induced by kickbacks and bribes, which they’d conspire to pay and receive.

Simpson's pharmacies allegedly submitted approximately $170 million in fraudulent claims through DOL-OWCP.

To cover her tracks, Simpson conspired to launder the proceeds of the criminal activity through financial transactions greater than $10,000. But once she learned about the investigation, officials say she converted those proceeds to cash and transferred them to over 10 bank accounts and a cryptocurrency wallet.

Source: ABC

Cigna to Pay $172M to Settle Claims of Wrongful Reimbursement by Medicare dvantage

Bogus bills by Cigna Corp. led to the health insurance giant collecting tens of millions of dollars through the Medicare Advantage program, according to the U.S. Department of Justice (DOJ).

The federal government has filed a civil healthcare fraud lawsuit against Cigna and its subsidiary Medicare Advantage organizations. DOJ alleges Cigna violated the federal False Claims Act by submitting "false and invalid patient diagnosis codes to artificially inflate the payments Cigna received for providing insurance coverage to its Medicare Advantage plan members."

Although the complaint did not appear to include an exact tally, it stated Cigna used fraudulent billing to pocket about $61.8 million for 2014 and about $38.8 million for the first eight months of 2015. DOJ is asking the federal court for treble damages that would amount to millions.

"As alleged, Cigna obtained tens of millions of dollars in Medicare funding by submitting to the government false and invalid diagnoses for its Medicare Advantage plan members," U.S. Attorney Damian Williams said in a news release. "Cigna knew that, under the Medicare Advantage reimbursement system, it would be paid more if its plan members appeared to be sicker. This office is dedicated to holding insurers accountable if they seek to manipulate the system and boost their profits by submitting false information to the government."

The lawsuit was filed as part of an earlier whistleblower complaint first filed in the U.S. District Court-Southern District of New York and that remains pending in the U.S. District Court-Middle District of Tennessee.

The lawsuit alleges Cigna hired vendors to conduct home visits of patients who had Medicare Advantage insurance, as part of the company's "360 comprehensive assessment" program. Nurse practitioners, physician assistants, and registered nurses usually conducted the visits and used a "360 form" with a check-the-box, multipage list of medical conditions.

"CIGNA structured the 360 home visits for the primary purpose of capturing and recording lucrative diagnosis codes that would significantly increase the monthly capitated payments it received from CMS," said a summary of the case from DOJ.

Cigna prohibited the vendors from providing patient treatment or care. The vendors did not conduct comprehensive physical examinations, did not have patient records from primary care physicians, and "generally lacked the equipment necessary to diagnose serious, complex conditions in the home setting," according to the DOJ summary and legal complaint.

Source: Medicaleconomics

Nearly 400 New Diagnosis Codes - 2024

Of the 395 new codes, 123 of them reside in the external causes of morbidity chapter of the ICD-10-CM manual, specifically new codes to capture accidents and injuries.When it comes to SDOH, there are 30 new diagnosis codes for factors influencing health status and contact with health services.Staying abreast of code updates is important as robust data related to patients' needs is critical to hospitals' efforts to improve the health of their patients and communities.

For example, the final update confirms the introduction of five new codes for Parkinson's disease:

- G20.A1, Parkinson's disease without dyskinesia, without mention of fluctuations
- G20.A2, Parkinson's disease without dyskinesia, with fluctuations
- G20.B1, Parkinson's disease with dyskinesia, without mention of fluctuations
- G20.B2, Parkinson's disease with dyskinesia, with fluctuations
- G20.C, Parkinsonism, unspecified

An extensive "code also" update for "other specified problems related to upbringing" says codes for the following diagnoses should also be reported when applicable:

Source: healthleadersmedia

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Pediatric Craniosynostosis Coding in ICD-10-CM

Craniosynostosis, a complex craniofacial condition, impacts approximately one in every 2,500 babies in the United States. This article delves into the complexity of this congenital disability, shedding light on its various forms, categorized broadly by either an unknown cause or an underlying condition. Moreover, we explore ICD-10-CM coding for these diagnoses, including the recent updates as of October 1 of this year, designed to reflect the diverse types of craniosynostosis.

Figure 1

Understanding Craniosynostosis

See Figure 1, which represents the normal skull of a newborn, showing the major cranial sutures, including the metopic, coronal, sagittal, and lambdoid sutures.

Figure 1 - Right

Craniosynostosis is a congenital skull malformation resulting from the premature fusion of one or more cranial sutures, the fibrous joints that connect the bones of an infant's skull. These sutures allow the skull to expand as the brain grows. Premature fusion of one or more of these sutures can lead to an irregular head shape and potential complications.

Commonly referred to as "craniostenosis" or "synostosis," the term "craniosynostosis" can be dissected to unveil its meaning: "cranio-" pertains to the cranium or skull, while "synostosis" signifies the fusion of two or more bones.

Symptoms of Craniosynostosis

The primary symptom of craniosynostosis is an atypical head shape known as plagiocephaly, which may become evident shortly after birth or become more pronounced as the child grows. For instance, one side of the face may exhibit noticeable asymmetry compared to the other.

Additional indicators may include a full or bulging fontanelle (the soft spot on the top of the head), prominent scalp veins, heightened irritability, a high-pitched cry, feeding difficulties, recurrent vomiting, an expanding head circumference, and developmental delays.

Etiology and Risk Factors

The precise cause of craniosynostosis can vary and may result from a combination of genetic and environmental factors. In some cases, craniosynostosis is linked to specific genetic syndromes, while in others, it may occur spontaneously without an apparent underlying cause.

Factors that can increase the chance of an infant developing craniosynostosis include maternal thyroid disease or using certain medications like clomiphene citrate (a fertility drug) shortly before or during pregnancy.

Diagnosing Craniosynostosis

Typically, craniosynostosis is assessed through physical examination by palpating the skull for suture ridges and soft areas. It also involves evaluating neck alignment and facial irregularities. However, a radiological assessment is often necessary to confirm the diagnosis, assess the extent of the deformity, and determine the most appropriate course of surgical treatment. While a standard X-ray can reveal the deformity, computerized tomography (CT or CAT scans) offers more detailed insights into the fused sutures and the condition of the underlying brain. Furthermore, three-dimensional (3-D) CT scans can furnish additional details to guide corrective surgical measures.

Exploring the Types of Craniosynostosis

Craniosynostosis can be categorized as nonsyndromic, developing independently without other related abnormalities, or syndromic, originating from an underlying genetic condition. The various types of craniosynostosis are based on the number of fused bones, which influence the shape of the child's head. These types encompass single-suture synostosis (primary), double-suture synostosis, and complex multi-suture synostosis.

Single-Suture Synostosis (Primary)

Examples of single suture synostosis, when one skull suture fuses, include:

- **Sagittal synostosis (scaphocephaly):** The most prevalent form of craniosynostosis, sagittal synostosis occurs when the sagittal suture fuses prematurely. This fusion results in the elongation of the baby's head in a narrow manner, known as scaphocephaly.
- **Unilateral coronal synostosis (anterior plagiocephaly):** The second most common type of craniosynostosis, unilateral coronal synostosis happens when one side of the coronal suture fuses prematurely. This fusion leads to a flattened forehead on the side of the skull where closure occurs (anterior plagiocephaly) and an almond-shaped eye socket.
- **Lambdoid synostosis (posterior plagiocephaly):** Lambdoid synostosis represents one of the rarer forms of craniosynostosis. Premature fusion of this suture can flatten the back of the baby's head (posterior plagiocephaly), making one ear appear higher than the other.
- **Metopic synostosis (trigonocephaly):** Metopic synostosis is another infrequent variant. Premature closure of this suture can result in a triangular-shaped head characterized by narrowness in the front and width at the back (trigonocephaly).

Double-Suture Synostosis

If two skull sutures fuse prematurely, the condition is referred to as double-suture synostosis. Examples of this type include:

- **Bicoronal synostosis (brachycephaly):** In this form, both sides of the coronal suture fuse prematurely, leading to a broad and shortened head (brachycephaly) and vertical growth in the skull (turribrachycephaly). Bicoronal synostosis is often diagnosed in children with Apert syndrome and Crouzon syndrome.
- **Bilambdoid synostosis:** Here, both sides of the lambdoid suture fuse, causing the skull to appear wider than normal (posterior brachycephaly).
- **Sagittal plus metopic synostosis:** In this case, both the sag-

ittal and metopic sutures fuse, resulting in a long and narrow-shaped head (scaphocephaly).

Complex Multisuture Synostosis

More than two skull sutures may fuse in rare instances, leading to complex multisuture synostosis. Examples of this include:

- **Bicoronal, sagittal, metopic:** This condition arises when the sagittal, metopic, and both sides of the coronal suture fuse. It results in a short and wide head, which may also exhibit a pointed appearance (turribrachycephaly).
- **Cloverleaf skull (Kleeblattschadel):** A rare form of craniosynostosis, cloverleaf skull occurs when the coronal, sagittal, and lambdoid sutures all fuse. It is often associated with severe cases of Apert syndrome, Crouzon syndrome, and Carpenter syndrome.
- **Pancraniosynostosis:** All the major sutures in the skull fuse in this exceptionally rare form.

Syndromic Craniosynostosis

Craniosynostosis can also be associated with an underlying genetic condition. Common syndromes linked to craniosynostosis include Crouzon, Apert, Carpenter, Pfeiffer, and Saethre-Chotzen.

- **Crouzon syndrome:** The most prevalent syndrome associated with craniosynostosis is Crouzon syndrome, particularly the bilateral coronal type. Individuals with Crouzon syndrome often exhibit midfacial abnormalities like forward protrusion of the eyes and airway obstruction. Some cases may also result in hydrocephalus, characterized as fluid buildup in the brain. Generally, there are no limb abnormalities. While a mutation in the FGFR2 gene primarily causes it, some cases occur spontaneously. Crouzon syndrome is also known as acrocephalosyndactyly and was initially termed craniofacial dysostosis.
- **Apert syndrome:** Also known as acrocephalosyndactyly type I, Apert syndrome is linked to bilateral coronal craniosynostosis. It results in a tall and shortened head, with the fusion of the skull base. Other common abnormalities may affect the hand, elbow, hip, and knee. Facial features often include eye protrusion, wide spacing between the eyes, a prominent pointed nose, and downward-slanting eyelids. These features are usually inherited, and developmental delays and intellectual disabilities are frequently observed in this syndrome.
- **Carpenter syndrome:** Frequently associated with lambdoid and sagittal synostosis, Carpenter syndrome can lead to limb abnormalities, including extra toes and heart issues. Carpenter syndrome, also called acrocephalopolysyndactyly type II, has not yet been associated with a specific gene.
- **Pfeiffer syndrome:** Also known as acrocephalosyntactyly type V, Pfeiffer syndrome is often linked to unicoronal craniosynostosis and includes limb abnormalities, midfacial deformities, protruding eyes, and hearing loss. Hydrocephalus is also a common occurrence. Three distinct types of Pfeiffer syndrome have been identified, with types 2 and 3 being the most severe.
- **Saethre-Chotzen syndrome:** Referred to as acrocephalosyntactyly type III, this congenital syndrome is frequently associated with craniosynostosis and limb abnormalities. Unlike the other syndromes, Saethre-Chotzen syndrome has a distinct genetic profile. Key features include coronal synostosis (often unilateral), a low-set hairline, eyelid abnormalities, facial asymmetry, and developmental delay.

Treatment for Craniosynostosis

Effective treatment options for craniosynostosis primarily involve surgical intervention to rectify the fused sutures, allowing for normal brain and skull growth. Surgical procedures such as cranial vault remodeling or endoscopic craniectomy can alleviate pressure within the head and correct facial and skull bone deformities.

Potential Complications

Craniosynostosis that goes untreated may lead to persistent deformities of the head and face, which can impact a child's self-esteem and social interactions. Additionally, untreated craniosynostosis, especially those linked to an underlying syndrome, can cause increased cranial pressure and potentially lead to developmental delays, cognitive impairment, blindness, seizures, and headaches.

ICD-10-CM Coding for Craniosynostosis and Craniosynostosis Syndromes

The ICD-10-CM codes for craniosynostosis and associated syndromes can be found in Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99).

Craniosynostosis in ICD-10-CM

Before October 1, 2023, craniosynostosis was reported with code Q75.0. However, this changed with the FY 2024 updates, which introduced a more detailed coding system. For instance, code Q75.0 evolved into category Q75.0, and several new codes were introduced based on the specific type of craniosynostosis.

These newly added codes include:

- Q75.001 - Craniosynostosis unspecified, unilateral
- Q75.002 - Craniosynostosis unspecified, bilateral
- Q75.009 - Craniosynostosis, unspecified
- Q75.01 - Sagittal craniosynostosis
- Q75.021 - Coronal craniosynostosis, unilateral
- Q75.022 - Coronal craniosynostosis, bilateral
- Q75.029 - Coronal craniosynostosis, unspecified
- Q75.03 - Metopic craniosynostosis
- Q75.041 - Lambdoid craniosynostosis, unilateral
- Q75.042 - Lambdoid craniosynostosis, bilateral
- Q75.049 - Lambdoid craniosynostosis, unspecified
- Q75.051 - Cloverleaf skull
- Q75.052 - Pansynostosis
- Q75.058 - Other multi-suture craniosynostosis
- Q75.08 - Other single-suture craniosynostosis

Craniosynostosis Syndromes in ICD-10-CM

ICD-10-CM codes for craniosynostosis syndromes remain consistent with FY 2023.

Crouzon syndrome is assigned its unique code:

- Q75.1 - Craniofacial dysostosis
- (Also referred to as Crouzon's disease)

Meanwhile, Apert, Pfeiffer, Carpenter, and Saethre-Chotzen syndromes share the same code and are reported along with various other syndromes, using:

- Q87.0 - Congenital malformation syndromes predominantly affecting facial appearance
- Acrocephalopolysyndactyly
- Acrocephalosyndactyly [Apert]
- Cryptophthalmos syndrome
- Cyclopia
- Goldenhar syndrome
- Moebius syndrome
- Oro-facial-digital syndrome
- Robin syndrome
- Whistling face

As mentioned earlier, Apert syndrome, Carpenter syndrome, and Pfeiffer syndrome are also known as acrocephalosyndactyly.

An instructional note at Q87 indicates an additional code (or codes) should be used to identify all associated manifestations.

All codes from Chapter 17 must be used on the baby's records, not the maternal records.

Conclusion

In summary, craniosynostosis can occur as a primary condition (nonsyndromic) or as part of a larger genetic syndrome (syndromic). In cases where a child experiences syndromic craniosynostosis and specific cranial sutures fuse, such as bi-coronal synostosis, a comprehensive evaluation by medical professionals is crucial for accurate diagnosis and management. Furthermore, medical coders must be well-versed in the various types of craniosynostosis and proficient at assigning the appropriate codes, including the newly expanded nonsyndromic codes that took effect on October 1 of this year.

Debbie Jones, CPC, CCA, is the writer and founder of Medical Coding Buff, a blog about medical coding. She helps individuals starting in their medical coding education who are interested in sitting for their CPC credentials. Besides her many articles on medical coding, she strives to make learning fun, engaging, and interactive by providing quizzes, multiple-choice challenges, and crossword puzzles. Receiving an associate's degree from Colorado Technical University (CTU-O) in 2012 in Medical Billing and Coding, Debbie graduated with highest honors. From there, she went on to earn her CCA, CPC-A (now CPC), and HCS-D credentials. She is a member of AAPC and AHIMA and a contributing writer for BC Advantage and JustCoding. She started her career in healthcare as a hospital admitting clerk before moving on to medical transcription for five years. You can reach Debbie at debbie@medicalcodingbuff.com or through her website at medicalcodingbuff.

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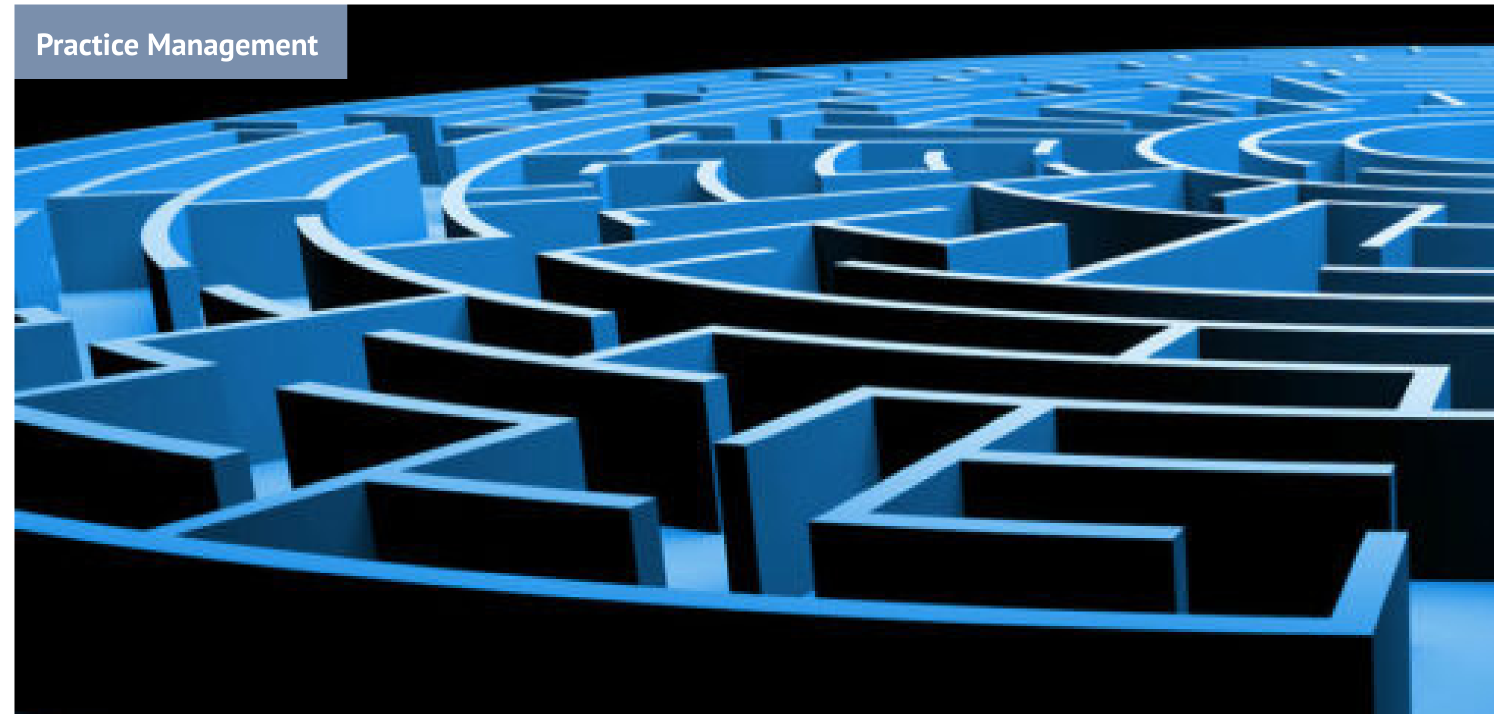


Decoding the Maze:

Navigating Prior Authorization in Healthcare

Picture this: You're at a hospital, and amidst the stress of an upcoming procedure, you're swamped with paperwork and concerns about the treatment's financial aspect.

This scenario is all too common, and at its core often lies the concept of prior authorization. As the healthcare sector evolves, managing aspects like prior authorization and benefit verification has become paramount. Why? Let's embark on this journey to understand more.

Decoding Prior Authorization: What Is It?

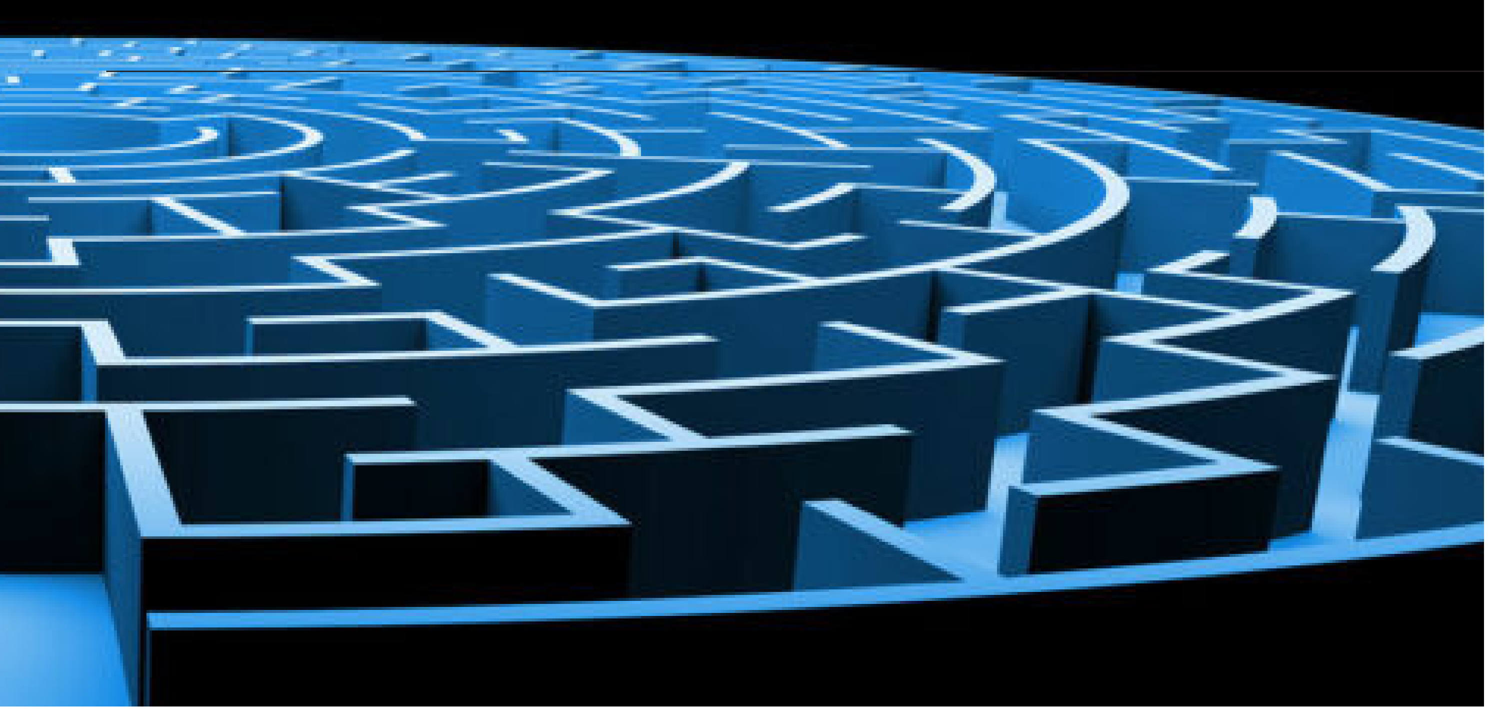
In essence, prior authorization is a checkpoint. It's where insurance companies require healthcare providers to obtain approval before rendering specific services to patients. Think of it as a bridge between the clinical aspect of care and its economic side. It ensures that a given treatment or test is medically necessary and aligns with the patient's insurance plan.

Beyond the jargon, its role is twofold:

- **Patient Care:** It ensures patients receive treatments that are clinically appropriate.
- **Healthcare Economics:** By regulating procedures, it indirectly impacts healthcare costs and billing structures.

The Integral Nature of Verifying Benefits

When we talk about benefit verification, we're delving



into the realm of transparency. It's about ensuring that patients understand their insurance coverage, from treatments to medications and everything in between.

This clarity plays a pivotal role in:

- **Direct Patient Care:** It aids in deciding treatment options that are both clinically sound and financially feasible.
- **Billing Predictability:** When healthcare providers know the coverage specifics, it reduces billing errors and the nasty surprises of unforeseen medical bills for patients.

The Impact of Prior Authorization on Patient Care

Imagine a world without prior authorization. A patient could undergo a costly procedure only to later find out that their insurance doesn't cover it. The aftermath? Financial strain and dissatisfaction.

The beauty of prior authorization lies in its systematic approach:

- **Streamlining Processes:** For healthcare providers, it means a more organized system of admitting and treating patients.
- **Financial Clarity:** Patients are shielded from unforeseen medical expenses. They have a clearer picture of their potential financial responsibility.
- **Aligned Care:** By ensuring that treatments match insurance protocols, there's a harmony between clinical decisions and insurance provisions.

The Process of Prior Authorization: Step-by-Step

Much like baking a cake, prior authorization has its steps and ingredients. Let's walk through them:

Initial Information Gathering

This is the prep phase. It involves collecting patient data, understanding the medical necessity of a procedure, and collating all essential documentation.

Submission

The prepared "request" is then sent over to the insurance company. Think of this as placing your cake in the oven.

The Wait

Once submitted, there's an anticipatory period where one awaits a nod (or shake) of approval. The insurance company, at this juncture, can either give the green light (approval), halt the process (denial), or ring back asking for more details.

Challenges in the Prior Authorization and Benefits Verification Process

Before we forge solutions, we must understand the roadblocks:

- **Delays in Treatment:** Imagine you're awaiting a crucial treatment, but there's this waiting period due to the prior authorization process. Time-sensitive treatments can be particularly impacted, leading to patient stress and complications.
- **Potential Denials and Resubmission:** Sometimes, the insurance company might respond with a "no." Now, there's the hustle of understanding why and redoing the process, all while the clock is ticking.
- **Ever-Changing Insurance Terrain:** Insurance policies aren't static. They're evolving landscapes with periodic changes, making it challenging for hospital staff to always stay informed.

The Importance of Continuous Training for Hospital Staff

With challenges identified, let's talk solutions:

- **Adapting to Change:** It's crucial for staff to be updated on insurance policy alterations and new regulations. Think of it as software updates for your computer; you need them for optimal performance.
- **Minimizing Errors:** Continuous training sharpens skills, reduces mistakes, and streamlines the prior authorization process.
- **Fostering Transparency:** A well-informed staff can communicate effectively with patients, providing clarity on the nuances of their insurance coverage and what to expect in terms of treatment and billing.

Best Practices in Prior Authorization and Benefits Verification

If prior authorization is a maze, then best practices are your cheat codes:

Robust Patient Records

Ensure comprehensive patient records are maintained. For instance, a patient with a history of allergies might need specific medications. Accurate records ensure that treatments align with the patient's medical history and that there are no hiccups in getting insurance approvals.

Teamwork Makes the Dream Work

Establish open channels of communication between departments—from the medical team to the administrative staff. Collaborative discussions can quickly resolve doubts and ambiguities, leading to smoother insurance submissions.

Efficient Submissions

Reducing waiting times is pivotal. Streamline submissions by using electronic health records (EHR) systems that often have integrated features for prior authorization. This not only accelerates the process but also reduces manual errors.

Conclusion

Let's step back and look at the big picture. Prior authorization, for all its intricacies, plays a pivotal role in ensuring that healthcare remains both quality-driven and economically viable. It's the balancing act between medical necessity and financial feasibility.

However, the process is not without its hurdles. And that's okay! Like any system, it requires constant refinement. By investing in continuous training and adopting best practices, healthcare providers can navigate this maze with finesse. Most importantly, maintaining transparent communication lines with patients ensures they remain informed and reassured.

As we conclude our exploration of prior authorization, let's remember one thing: The heart of this process, amidst all its paperwork and procedures, is the patient. When we prioritize their well-being, both medically and financially, we truly uphold the sanctity of healthcare.

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Introduction to Telebehavioral Health

Delivering mental health services via telehealth has increased since the COVID-19 pandemic. Both federal and state rules are constantly evolving along with the use of Artificial Intelligence (AI), creating a complex environment for compliance considerations. This article is not intended as legal or consulting advice. If your practice is currently using a telebehavioral health approach for patient treatment, or if your organization is considering implementing this approach, we hope this article will give some food for thought on the topic. Keep in mind that coding and documentation is extremely important for psychiatric services – consider registering for the Psychiatric Compliance coding and documentation short course offered by the American Institute of Healthcare Compliance.

Telemedicine is considered to be under the umbrella of telehealth and refers specifically to clinical services. Telehealth and telemedicine cover similar services, including medical education, remote patient monitoring, patient consultation via videoconferencing, wireless health applications, and transmission of imaging and medical reports.

Behavioral telehealth may also be referred to as telebehavioral health, telemental health, telepsychiatry, or telepsychology.

Higher rates of use of telehealth are now standard in many practices since the coronavirus disease 2019 (COVID-19) pandemic. Increasing importance on patient

satisfaction, providing efficient and quality care, and minimizing costs have also led to higher telehealth implementation.

This increase in telebehavioral health has been especially enjoyed by both patients and providers since the pandemic, but widespread adoption has been hindered by regulatory, legal, and reimbursement barriers.

Individual, one-on-one therapy is the most common form of behavioral and mental health treatment. Telehealth can be an effective way to deliver individual therapy as long as your practice carefully considers compliant technology, implementation, and reimbursement concerns. Medicare covers many telebehavioral and telemental health services, including audio-only services. Most private insurers and Medicaid cover telebehavioral healthcare, but check for reimbursement restrictions and obtain professional coding and billing guidance to avoid overpayment situations.

Substance use disorders impact a significant number of individuals, families, and communities. When used in combination with other treatment methods, telebehavioral health interventions can be part of an integrated approach to treating substance use disorders. These interventions can include screening and diagnosis, online counseling, consults for prescriptions, and individual and group talk therapy. Treating substance use disorders via telehealth requires expertise and training in addiction care.

Benefits of Using Advanced Technology

The terms telehealth and telemedicine are often used interchangeably. Telehealth is a subset of e-health and is the use of telecommunications technology in healthcare delivery, information, and education according to the Health Resources and Services Administration (HRSA).

Telehealth has been used to bring healthcare services to consumers in distant locations, but became a necessity with the COVID-19 pandemic. Telehealth effectively connects individuals and their healthcare providers when in-person care is not necessary or possible. Using telehealth services, patients can receive care, consult with a provider, get information about a condition or treatment, arrange for prescriptions, and receive a diagnosis. In the 30 plus years that telehealth has been in use, it has been consistently shown to be a safe and quality care modality, a convenient option for both patients and the clinicians who care for them, and a secure environment for the collection and transmission of personal health information. In combination, these attributes extend where and how care is delivered for a stronger healthcare system.

Provider Shortages

Given provider shortages around the world, telehealth has a unique and appealing value proposition. It can provide millions of people in both rural and urban areas access to safe, effective, and appropriate care when and where they need it.

Cost-Benefit

Reducing or containing the cost of healthcare is one of the strongest motivators to fund and adopt virtual care technologies. Telehealth reduces the cost of healthcare and increases efficiency with better management of chronic diseases, shared health professional staffing, reduced travel times, and fewer or shorter hospital stays.

Meeting Patient Expectations

Patients utilizing telehealth during the pandemic may continue to expect remote care. Using telehealth technologies reduces travel time and related stresses for the consumer.

Understanding the Technology

Gaining a basic understanding of the technology will help you and your organization make informed choices about telehealth purchases. Terminology used for the various forms of telehealth technology are summarized below, which applies to both general and behavioral healthcare use. Not all forms of technology are recognized as services that can be reimbursed by health insurance.

Chat-Based (Asynchronous)

This approach is online or through a mobile app communication which transmits the patient's personal health data, vital signs, and other physiologic data or diagnostic images to a healthcare

provider to review and deliver a consultation, diagnosis, or treatment plan at a later time. This is also called "store-and-forward telemedicine."

Store-and-forward is less commonly reimbursed by Medicare and Medicaid programs. In many states, the definition of telemedicine and/or telehealth stipulates that the delivery of services must occur in "real time," automatically excluding store-and-forward as a part of telemedicine and/or telehealth altogether.

Mobile Health (mHealth)

Mobile Health, otherwise known as mHealth, utilizes smart devices and can now be used for many specialized aspects of healthcare that benefit from continuous data collection about a person's behavior or condition. Smartphones, tablets, and smart wearables like smart watches can monitor a variety of factors such as pulse rate, heart rate, and with some, blood sugar levels or quality of expired air. Apps are now available to encourage healthier lifestyles and behaviors by providing heart-rate variability scores, sleep cycles, movement tracking, weight changes, dietary tracking, and much more.

Remote Patient Monitoring or RPM

The remote patient monitoring approach supports ongoing condition monitoring and chronic disease management and can be synchronous or asynchronous, depending upon the patient's needs. The application of emerging technologies, including artificial intelligence and machine learning, can enable better disease surveillance and early detection, allow for improved diagnosis, and support personalized medicine. This includes the collection, transmission, evaluation, and communication of the patient's health data to the provider or extended care team from outside a hospital or clinical office. It involves using personal health technologies, including wireless devices, wearable sensors, implanted health monitors, smartphones, and mobile apps.

Virtual Visits (Synchronous)

This approach includes live, synchronous, and interactive communication during the encounter between the patient and healthcare provider. This is accomplished via video, telephone, or live chat.

Facing Implementation Challenges

Healthcare providers should keep risk management strategies in mind and familiarize themselves with potential telehealth legal risks and implications. This will ensure best practices for patient care and avoid licensure or litigation issues.

Telehealth faces many legal and regulatory hurdles, including large variations in rules, regulations, and guidelines for practices, which contributes to the confusion for providers engaged in the practice of telehealth.

Telehealth rules and regulations vary greatly by state; keep in mind:

- Providers should have awareness of and maintain compliance with state and federal legal requirements while using best practice guidelines to provide patient safety.
- The lack of multistate licensure presents a barrier to telehealth because providers must obtain and uphold licensure (and the associated medical education and financial obligations) in multiple states.

The Federation of State Medical Boards created the Interstate Medical Licensure Compact to ease portability of licensure and the practice of telemedicine from state to state for physicians and physician assistants.

Some key notes:

- Under the compact, state medical boards would maintain licensure and disciplinary authority of providers. However, they would share information and processes essential to these providers' licensure and regulations.
- This compact does not apply to nurse practitioners (NPs) because they are licensed under state boards of nursing and not medicine.
- Because state regulation and practice authority vary from state to state, NPs face more barriers than physicians or physician assistants.

Compared with face-to-face encounters, telemedicine encounters are more vulnerable to privacy and security risks.

Your telehealth platform should be secure in accordance with several laws, including:

- Health Insurance Portability and Accountability Act (HIPAA)

- Health Information Technology for Economic and Clinical Health (HITECH)
- Children's Online Privacy Protection Act (COPPA)

These laws protect medical information for both face-to-face and telehealth encounters, which include privacy, security, and protection for health information collected by covered entities such as healthcare plans, healthcare clearinghouses, and healthcare providers who use electronic resources for the transmission of healthcare information.

Only Consider Using HIPAA-Compliant Technology

The HIPAA rules establish standards to protect patients' protected health information. All telehealth services provided by covered healthcare providers and health plans must comply with the HIPAA rules.

Covered healthcare providers and health plans must use technology vendors that comply with the HIPAA rules and will enter into HIPAA business associate agreements in connection with the provision of their video communication products or other remote communication technologies for telehealth.

The Office for Civil Rights (OCR) is the HIPAA enforcement agency. OCR released guidance on April 12, 2023, to help covered healthcare providers and health plans understand how they can use remote communication technologies for audio-only telehealth. This information was published due to the end of the COVID-19 Public Health Emergency (PHE) which began May 12, 2023.

For more information, read the OCR's guidance, "How the HIPAA Rules Permit Covered Health Care Providers and Health Plans to Use Remote Communication Technologies for Audio-Only Telehealth."

Comply With Consent Requirements

Most states have telehealth-specific informed consent requirements in their statute, administrative code, and/or Medicaid policies. This requirement can sometimes apply to specific types of professionals when located in laws or regulations governing their profession. The requirement for consent is sometimes paired with other requirements, such as the need to ensure that the same level of care is delivered via telehealth as would be expected in person.

Make sure to have your medical/intake forms reviewed by your legal team. Obtaining informed consent with your patient is typically done before the first appointment. For the interactive map to research your state, provided by the Center for Connected Health Policy (CCHP), federally designated as the National Telehealth Policy Resource Center, visit: https://www.cchpca.org/topic/consent-requirements-professional-requirements/.

Another resource is an AHRQ resource page, "How to Obtain Consent for Telehealth," which provides discussion tips for before and during the consent periods.

Other Compliance Considerations

Compliance with both federal and state privacy rules should be at the forefront of any telehealth endeavor, but none so important as those services provided by behavioral health professionals. Telehealth providers must take responsibility for ensuring compliance with regulations, patient confidentiality, and system security at all times when practicing in a telehealth model.

The practice of telehealth raises many questions regarding malpractice liability, including informed consent (addressed in more detail below), practice standards and protocols, supervision requirements for nonphysician providers, and the provision of professional liability insurance coverage.

Important to remember:

- Simply applying existing principles of malpractice liability to telehealth is not straightforward, especially when it is unclear what an appropriate "standard of care" is.
- Professional liability policies may not include telehealth in the scope of coverage. Providers need to be cognizant of what exactly liability insurance policies cover, especially when providing telehealth services in other states.

In addition to knowledge of legal aspects of telehealth, it is important for providers to be aware of and practice telehealth etiquette. These etiquette standards should be observed when providers are working remotely at home or performing telehealth visits at their practice location. Also follow all clinical standards for care and adhere to practice standards determined by the profession, state regulatory boards, and state law. Reference the CCHP Professional Boards Standards interactive

map.

Providers should be appropriately licensed, credentialed, or certified to deliver care and permitted to practice without impermissible influence on their clinical judgement.

As telehealth use grows, caution and care should be taken to ensure that the practice of telehealth does not violate federal antikickback and Stark Law statutes. These laws prohibit providers from receiving compensation for accepting or making referrals to other facilities or providers where the referring provider has financial interests.

This includes understanding various fraud and abuse laws, as:

- Violations of these laws can result in fines, prison time, and/or exclusion from the Medicare and/or Medicaid programs.
- The federal Physician Self-Referral Law, also referred to as the Stark Law, prohibits a healthcare provider (or an immediate family member of a provider) from referring Medicare patients to entities providing designated health services if that provider or the provider's immediate family member has a financial interest.

When considering potential fraud and abuse scenarios and related risks, a provider needs to keep in mind that each state has its own variations of these laws. A state-by-state analysis is necessary because of variations in statutes and/or regulations.

Advertising for virtual care services should be truthful and non-misleading and demonstrate a commitment to quality healthcare that meets the standard of care and compliance with all applicable state and federal laws. The use of these telehealth appointments boomed during the pandemic. However, there are concerns about the quality of care patients receive and whether telehealth services are accessible to everyone, according to the September 2022 GAO article, "Telehealth in the Pandemic - How Has It Changed Health Care Delivery in Medicaid and Medicare?" Any website or other promotion offering behavioral health services via telemedicine or telehealth should be reviewed by legal counsel or your Risk Attorney (free) through your malpractice insurance company.

Written in collaboration with the AIHC Volunteer Education Committee.

The American Healthcare Institute of Healthcare Compliance (AIHC) is a 503(c)(3) organization and an internationally recognized leader in healthcare compliance training and certification.

Learn more about the AIHC Psychiatric Compliance - Short Course in Documentation and Coding at: https://aihc-assn.org/courses/psychiatric-compliance-a-short-course-in-documentation-and-coding/.

Free Available Resources

For additional information, view the following resources:

- American Telemedicine Association (ATA): https://www.americantelemed.org/about-us/
- American Psychiatric Association - Telepsychiatry: https://www.psychiatry.org/patients-families/telepsychiatry
- Arizona Telemedicine Program: How AI Helps Physicians Improve Telehealth Patient Care in Real-Time (June 2023): https://telemedicine.arizona.edu/blog/how-ai-helps-physicians-improve-telehealth-patient-care-real-time
- Center for Connected Health Policy (CCHP) - Nonprofit Organization Federally Designated as the National Telehealth Policy Resource Center: https://www.cchpca.org/
- Government Accountability Office (GAO) - Medicare Telehealth: Actions Needed to Strengthen Oversight and Help Providers Educate Patients on Privacy and Security Risks: https://www.gao.gov/products/gao-22-104454
- Telehealth.HHS.gov: https://telehealth.hhs.gov/patients/telehealth-and-behavioral-health-https://telehealth.hhs.gov/providers/billing-and-reimbursement

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Why Support for H.R. 2474
Is Important to Your Radiology Practice

The Strengthening Medicare for Patients and Providers Act (H.R. 2474) would modify the way the Medicare Physician Fee Schedule (MPFS) is calculated and adjusted each year. The basic system of determining Relative Value Units (RVU) would not change, but the annual adjustment of the Conversion Factor (CF) would more closely reflect the actual economic factors that affect physicians' practices.

If this bill is passed, the CF update would be calculated using the percentage increase in the Medicare Economic Index (MEI) beginning in 2024. It would also employ a single CF for all physicians in place of the current system that provides higher reimbursement to physicians who participate in a qualifying Advanced Alternative Payment Model (APM).

As described on the Medicare website, "The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The MEI includes a bundle of inputs used in furnishing physicians' services such as physician's own time, non-physician employees' compensation, rents, medical equipment, etc. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies."

Although the current law specifies the MEI as the basis for the annual CF update, the MEI is modified by another factor known as the Sustainable Growth Rate (SGR), which is a target against which actual Medicare expenditures are compared. The idea behind the SGR was to limit the growth of the federal budget; however, its effect has been to severely restrict payments to physicians that fail to reflect the real cost of providing healthcare.

A study published August 31, 2023, in the Journal of the American College of Radiology found that, "Between 2005 and 2021, the conversion factor declined 7.9%, and when adjusted for inflation, it declined 33.6%."

Additionally, the study concluded, "From 2005 to 2023, the inflation-adjusted conversion factor declined 43.1%." Additional metrics gleaned from the study are shown in the table. See Table 1.

H.R. 2474 has bipartisan support in the House. It was introduced by Democrat Paul Ruiz and originally co-sponsored by Republicans Larry Bucshon and Mariannette Miller-Meeks, with a total of 40 representatives (22 Democrats and 18 Republicans) signing on as co-sponsors as of this writing. Contact your representative and urge them to support H.R. 2474 by becoming a co-sponsor. For the most impact, be sure to have every member of your group contact their representative, and don't forget to include the members of your management team, as well.

Passage of this bill would go a long way toward allowing the Medicare fee schedule to reflect the ever-increasing cost of providing high-quality healthcare services. We will continue to monitor its progress and keep you abreast of this and other changes that impact your reimbursement.

Table 1

Compilation of Data from the Study: "Budget Neutrality and Medicare Physician Fee Schedule Reimbursement Trends for Radiologists, 2005 to 2021"

Measurement	2005	2021	% change	% change adjusted for inflation
Total Radiology Medicare Payment	$6.2 billion	$5.8 billion	5.5% reduction	31.9% reduction
Reimbursement based upon the Conversion Factor change	$37.8975 per RVU	$34.8931 per RVU	7.9% reduction	33.6% reduction
Reimbursement per Medicare beneficiary to radiology	$182	$189	4.2% increase	24.9% reduction
Total RVUs performed per Medicare beneficiary by radiologists	4.798	5.429	13.1% increase	N/A

(Source: Published August 31, 2023, DOI: https://doi.org/10.1016/j.jacr.2023.07.009)

Sandy Coffta is Vice President, Client Services Healthcare Administrative Partners. Healthcare Administrative Partners (HAP) provides revenue cycle management, clinical analytics, and comprehensive practice management solutions for radiology practices. They also provide coding services for multispecialty practices. HAP produces results, not promises. Their key to optimizing your success is to aggressively improve all areas of your practice's financial health – maximizing reimbursements and accelerating cash flow while reducing cost and compliance risk. www.hapusa.com

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2024

ICD-10-CM Code Changes

It's that time of the year again. The new ICD-10-CM code books are out, and the changes are now active. There are 395 new diagnosis codes, 25 deleted codes, and 12 revised codes for 2024. As a healthcare professional, the ability to understand and navigate the updated ICD-10-CM codes is integral. Mistakes or misunderstandings can lead to claim denials, inaccurate data collection, and potential patient harm. It is vital to engage in continued education to understand these changes fully. This article will provide an overview of the new codes for ICD-10-CM for 2024.

Guideline Changes

There were a few guideline additions and changes for 2024. The guideline for sepsis (I.C.1.d.5.b) has been revised to notate that if a patient has sepsis from a surgical wound, the code for infection following a procedure or infection of an obstetric wound should be reported first. There is a new COVID guideline that states code Z11.52 for screening for COVID-19 (I.C.1.g.1.f). New guideline I.C.9.e.6 gives instruction on when to report code I21.B for myocardial infarction with coronary microvascular dysfunction. One of the coma guidelines (I.C.18.e) has been clarified to state the unspecified coma code R40.20 should be assigned only when the cause of the coma is unknown, or the cause is a traumatic brain injury (TBI), and the coma scale is not documented. Finally, guideline I.C.21.c.8 regarding follow-up care states that code categories Z08 (encounter for follow-up after completed treatment for malignant neoplasm) and Z09 (encounter for follow-up after completed treatment for conditions other than malignant neoplasm) may be assigned following any type of completed treatment modality whether the treatment was medical or surgical.

New ICD-10-CM Codes

To understand the breakdown of the new codes by ICD-10-CM chapter, see the table on page 28.

Chapter	Additions
1: Certain Infectious and Parasitic Diseases	2
2: Neoplasms	13
3: Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism	8
4: Endocrine, Nutritional, and Metabolic Diseases	18
5: Mental and Behavioral Disorders	0
6: Diseases of the Nervous System	24
7: Diseases of the Eye and Adnexa	34
8: Diseases of the Ear and Mastoid Process	0
9: Diseases of the Circulatory System	10
10: Diseases of the Respiratory System	7
11: Diseases of the Digestive System	17
12: Diseases of the Skin and Subcutaneous Tissue	0
13: Diseases of the Musculoskeletal System and Connective Tissue	36
14: Diseases of the Genitourinary System	15
15: Pregnancy, Childbirth, and the Puerperium	6
16: Certain Conditions Originating in the Perinatal Period	0
17: Congenital Malformations, Deformations, and Chromosomal Abnormalities	22
18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	18
19: Injury, Poisoning, and Certain Other Consequences of External Causes	12
20: External Causes of Morbidity and Mortality	123
21: Factors Influencing Health Status and Contact With Health Services	30

Let's take a deeper dive into the new codes by chapter.

Chapter 1: Infectious and Parasitic Diseases

There are two new codes for chapter 1 that relate to Acinetobacter baumannii infections. These Gram-negative bacteria are present everywhere in the environment and can live on human skin. Some types of Acinetobacter can cause blood, lung, or urinary tract infections and are a major cause of hospital-acquired infections in critically ill patients with ventilator-associated pneumonia and bloodstream infections. In 2017, Acinetobacter baumannii was responsible for about 8,500 infections and 700 deaths in U.S. hospitals. ICD-10-CM code A41.54 is for sepsis due to Acinetobacter baumannii, and B96.83 is used to report Acinetobacter baumannii as the cause of diseases classified elsewhere.

Chapter 2: Neoplasms

There are 11 new codes for desmoid tumors, also called aggressive fibromatosis, in chapter 2. Desmoid tumors are noncancerous growths occurring in the connective tissue, which provides strength and flexibility to structures like bones and muscles. They most often occur in the abdomen, arms, and legs, but can form anywhere in the body. The new codes are in category D48 and range from D48.110 to D48.19 and specify body sites such as chest wall, upper and lower extremities, and back.

ICD-10-CM code D13.91 has been added for familial adenomatous polyposis (FAP), which is an inherited condition that predisposes patients to colon polyps and colon cancer. According to Cancer.Net, if not removed, the estimated cancer risk associated with FAP is up to 100% for colorectal cancer. There are three types of FAP: classic, attenuated, and autosomal. Classic FAP is characterized by more than 100 adenomatous polyps in the colon, usually starting in the teenage years. These polyps can become cancerous, on average by age 39. The attenuated form of FAP is less severe where patients have between 20 and 100 polyps and is slower in becoming cancerous (around age 55). Autosomal recessive FAP is less aggressive with fewer than 100 polyps noted and less severe.

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Code Z83.710 has also been added to indicate a family history of adenomatous and serrated polyps. The classic and attenuated forms are caused by mutations in the adenomatous polyposis coli (APC) gene (suppresses tumor growth), and the autosomal form is caused by mutations in the MUTYH gene (helps prevent cancers). ICD-10-CM code D13.99 was also added for benign neoplasms of ill-defined sites within the digestive system.

Chapter 3: Disease of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism

There are six new codes for reporting sickle-cell disorders, which affect the body's hemoglobin. Hemoglobin is the protein in red blood cells that carries oxygen. In sickle cell disorders, the hemoglobin does not carry oxygen as well, causing the red blood cells to clump together, become stiff and sticky, and become sickle shaped (like a banana). Sickle cells can pile up and block blood flow or break apart and lead to jaundice, anemia, pain, and other complications.

The new codes for sickle cell disorders denote that the patient also has dactylitis, or a swelling of the fingers and/or toes.

The codes are located in the subcategories for sickle cell disease as follows:

- D57.04 - Hb-SS disease with dactylitis
- D57.214 - Sickle-cell/Hb-C disease with dactylitis
- D57.414 - Sickle-cell thalassemia, unspecified, with dactylitis
- D57.434 - Sickle-cell thalassemia beta zero with dactylitis
- D57.454 - Sickle-cell thalassemia beta plus with dactylitis
- D57.814 - Other sickle-cell disorders with dactylitis

The other two codes in chapter 3 are for Shwachman-Diamond syndrome (SDS) (D61.02) and IgG4-related disease (D89.84). SDS is a genetic disorder that affects the bone marrow, pancreas, and skeleton, leading to a weakened immune system. This makes a person prone to infections, and the lack of pancreatic enzymes leads to digestive issues. Some patients also have skeletal abnormalities. IgG4-related disease is an immune-mediated condition that causes tissue inflammation and elevated levels of the IgG4 antibody and can affect almost any organ. ICD-10-CM code D89.94 is the new code to indicate a patient with IgG4-related disease.

Chapter 4: Endocrine, Nutritional, and Metabolic Diseases

There are 18 new codes in Chapter 4, including codes for autosomal dominant hypocalcemia (ADH), lipid storage disorders, and metabolic disorders. Five of the new codes are related to ADH, which is a genetic disorder that affects calcium metabolism and is caused by mutations in the CASR or GNA11 genes. Type 1 ADH is caused by mutations in the calcium sensing receptor (CaSR) gene protein, and type 2 is caused by mutations in the GNA11 gene. The codes range from E20.810 to E20.819.

There are also four new codes for metabolic disorders (E88.810-E88.819), including insulin resistance. This occurs when cells in your muscles, fat, and liver don't respond as they should to insulin, a hormone the pancreas makes that regulates blood glucose levels. Insulin resistance can be temporary or chronic and is treatable in some cases. There are two types of insulin resistance: type A and type B.

Type A affects the body's ability to effectively process blood sugar and usually does not become apparent until puberty. Type B is very rare and is found in people with autoimmune disorders.

Chapter 6: Diseases of the Nervous System

The main new codes in chapter 6 are for Parkinson's disease, migraines, and epilepsy. The new codes for epilepsy are related to Lafora Progressive Myoclonus Epilepsy, or Lafora Disease, which is one of the most severe forms of epilepsy. It is characterized by the onset of seizures and progressive neurologic decline. The codes range from G40.C01 to G40.C19.

The new codes for Parkinson's disease relate to an expansion for Parkinson's with and without dyskinesia, which is involuntary, erratic movements of the muscles. These codes are G20.A1 to G20.A2, G20.B to G20.B2, and G20.C.

The new codes for migraines are for chronic migraines

with aura. Chronic migraine is classified as 15 or more headaches a month over three months with at least eight days a month with migraine. Aura indicates a sensory disturbance that can include flashes of light, blind spots, and other vision changes or tingling in the hand or face. These codes are G43.E01, G43.E09, G43.E11, and G43.E19, and are further broken down by with or without status migrainosus.

Chapter 7: Diseases of the Eye and Adnexa

Chapter 7 has 34 new codes and most of them are for extraocular muscle entrapment. There are six extraocular muscles: the superior oblique, inferior oblique, inferior rectus, lateral rectus, medial rectus, and superior rectus. They control eye movement and eyelid elevation. They are located from H50.62- to H50.68- with the 7th character denoting laterality. Extraocular muscle entrapment occurs when one of the eye muscles gets trapped in a fracture line of the orbital floor. It is more common in pediatric patients.

Chapter 9: Diseases of the Circulatory System

There are 10 new codes in chapter 9, and they include hypertension, angina pectoris, myocardial infarction, tachycardia, and ischemic heart disease. Code I1A.0 is for resistant hypertension, which is high blood pressure that remains elevated after the use of three antihypertensive medications from different classes. A few codes have been added that relate to coronary microvascular dysfunction (CMD), which affects the small blood vessels that branch off the main coronary arteries (microvasculature), leading to problems with the blood supply to the heart. Code I24.81 is used to report myocardial infarction with CMD, I24.81 is for acute CMD, and I24.85 denotes chronic CMD. There is also a code for other forms of acute ischemic heart disease, which is I24.89.

Chapter 10: Diseases of the Respiratory System

There were seven new codes added to chapter 10. As discussed in the codes for chapter 1, a new code has been added to report pneumonia due to Acinetobacter baumannii, along with J15.69 for pneumonia due to other Gram-negative bacteria.

There were also three new codes for lung transplant-related illnesses:

- J4A.0 - Restrictive allograft syndrome
- J4A.8 - Other chronic lung allograft dysfunction
- J4A.9 - Chronic lung allograft dysfunction, unspecified

Chapter 11: Diseases of the Digestive System

Chapter 11 has 17 new codes for 2024, including six new codes for acute appendicitis, five new codes for intestinal microbial overgrowth, and three new codes for short bowel syndrome (SBS). The new appendicitis codes are used to report acute appendicitis with generalized peritonitis that further break down to notate with and without perforation and with and without abscess. They range from K35.200 to K35.219. Intestinal microbial overgrowth codes encompass small intestinal bacterial overgrowth (SIBO), intestinal methanogen overgrowth (IMO), and small intestinal fungal overgrowth (SIFO). These conditions result in an imbalance of the microorganisms in the gut that maintain healthy digestion. When the bacteria overgrow, it can cause gas, diarrhea, and an inability to digest and absorb nutrients in food. The codes range from K63.821 to K63.829 and are broken down by type of overgrowth. The three new codes for short bowel syndrome (SBS) specify whether it is with or without colon in continuity. SBS is a rare malabsorption disorder that is caused by a lack of functional small intestine from having parts of the small intestine removed or being born with portions of the small intestine missing or damaged.

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue

Chapter 13 has 36 new osteoporosis codes, including 18 for age-related osteoporosis with current pelvis fracture and 18 for other osteoporosis with current pelvis fracture. The codes further specify laterality with 7th character extenders for all the codes.

Chapter 14: Diseases of Genitourinary System

Fifteen new codes were added in chapter 14 to indicate different types of nephropathy. Immunoglobulin A nephropathy (IgAN) is the most common form of nephropathy that can lead to end-stage renal disease with new codes under N02.B subcategory. The codes are broken down by manifestation (glomerular lesion and glomerulonephritis by type). Membranous nephropathy (MN) is a slowly progressive disease that occurs when the small blood vessels in the kidney become inflamed and thickened. The codes are found in

category N04 and are further specified to primary or secondary and type.

Chapter 15: Pregnancy, Childbirth, and the Puerperium

New codes were introduced in chapter 15 for intrahepatic cholestasis in pregnancy (ICP), which is a liver disorder that affects about 0.5% of pregnant women in the U.S. It poses a threat to the mother and baby for pre-eclampsia and preterm birth. These codes are O26.641 to O26.649.

Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities

A total of 22 codes have been added to chapter 17 that cover genetic disorders and congenital malformations. The largest group of codes relates to craniosynostosis which occurs when the joints between a baby's skull bones close too early. This affects the skull's shape and brain growth. The codes can be located from Q75.00- to Q75.029. The codes include laterality.

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified

The 18 new codes for chapter 18 include new codes for foreign body sensations to note when a patient feels like they have something stuck, but nothing is found. The codes are from R09.A0 to R09.A9 and are broken down by site. There are also new codes for different types of breast density (fatty tissue, fibroglandular, heterogeneous, and extreme) from R92.31- to R92.34- and indicate laterality. Breast density listed is categorized by the breast imaging-reporting and data system (BI-RADS). Breast density can affect readings of mammograms and the new codes aim to capture the findings to improve patient care.

Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes

There are twelve new codes for toxic effects of gadolinium, which is used in MRI contrast. Toxicity can occur within hours to years after an MRI scan. The codes are in the T56.8 subcategory and are broken down like other codes for this chapter: accidental, intentional self-harm, assault, and undetermined. There are also 7th character extenders for initial, subsequent, and sequela.

Chapter 20: External Causes of Morbidity

Most of the new codes (a whopping 123) for 2024 were added to chapter 20 and involve foreign bodies. The W44 category now has just about everything one can think of that can enter into or through a natural orifice, including batteries, plastic toys, plastic jewelry, plastic beads, plastic coins, sharp glass, magnetic metal coins, rubber bands, food, and insects. The codes have the usual 7th character extenders.

Chapter 21: Factors Influencing Health Status and Contact With Health Services

Thirty new Z codes have been added this year, including some social determinants of health (SDOH) codes for child/parent/guardian/relative conflict in the Z62 category of codes. Four new codes for family history of polyps are now available from Z83.710 to Z83.719. To add to the noncompliance codes, there are new codes for a caregiver's noncompliance with medication, renal dialysis, or other medical treatment for either financial hardship or other reasons in category Z91.

Conclusion

Healthcare professionals must grasp the implications of the new codes to ensure accurate documentation and billing, effective patient management, and up-to-date care techniques.

Betty Hovey, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, is the Senior Consultant/Owner of Compliant Health Care Solutions, a medical consulting firm that provides compliant solutions to issues for all types of healthcare entities.

Compliant Health Care Solutions (CHCS) was founded by Betty for Coders, Auditors, Physicians, Other Providers, Clinics, and Facilities need assistance in navigating today's healthcare environment, especially when it comes to coding and compliance. CHCS' philosophy is to offer every single client extraordinary service that is customized to their situation. No cookie-cutter answers here. Each person, practice, and situation is unique; so is their response. CHCS is honored to partner with every client they serve and will continue to show it for the long haul.
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- Apply the 2023 E/M definitions and guidelines in CPT to the medical record.
- Utilize the revised 2023 Medical Decision Making (MDM) Table in CPT to review E/M services.
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Betty A. Hovey is a seasoned healthcare professional with over three decades of experience in the field. She has extensive experience conducting audits for medical practices and payors. She specializes in educating various groups including coding professionals, auditors, doctors, APPs, payors, and others on coding, billing and related topics. Betty is a highly sought-after speaker and has co-authored manuals on ICD-10-CM, ICD-10-PCS, E/M, and various CPT specialty areas.

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Monthly Spotlight on Fraud, Waste, and Abuse

The following cases highlight fraud, waste, and abuse (FWA) and serve as a reminder to uphold high ethical standards when providing patient care and services.

Doctor Convicted for COVID-19 Healthcare Fraud Scheme

Early August saw a federal jury convicting a Maryland doctor for submitting over $15 million in false and fraudulent claims to Medicare and a commercial insurer for patients who received COVID-19 tests at his testing sites.

According to court documents and evidence presented at trial, this doctor was an owner and the medical director of an entity that operated multiple drive-through COVID-19 testing sites.

He instructed the employees that, in addition to billing for COVID-19 tests, the employees were also to bill for high-level evaluation and management (E/M) visits. These E/M visits were not provided to patients as represented. Rather, he instructed his employees that the patients were "there for one reason only – to be tested," that it was "simple and straightforward," and that the providers were "not there to solve complex medical issues."

The doctor ordered these high-level visits to be billed for all patients, including those who were asymptomatic, who were getting tested for COVID-19 for their employment requirements, and who were being tested for COVID-19 so they could travel.

The doctor, through his entity, caused the submission of millions of dollars in claims to Medicare and a commercial insurer for tens of thousands of high-level visits that were not provided as represented and were ineligible for reimbursement.

The jury convicted him of five counts of healthcare fraud. He is scheduled to be sentenced and faces a maximum penalty of 10 years in prison on each count.

He is the first doctor convicted at trial by the Justice Department for healthcare fraud in billing for office visits in connection with patients seeking COVID-19 tests.

A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Read the specifics of this case at www.justice.gov.

Neuroscience Company and Co-Founder/CEO to Pay $445,000 to Resolve False Claims Act Allegations Related to the Promotion of False Billing Codes

The company and CEO are to resolve alleged False Claims Act violations for causing the submission of false claims to Medicare by promoting false billing codes for a "brain health" device.

The CEO is a PhD psychologist, who co-founded the company as a startup in approximately 2009. The company sold its "eVox" device primarily to general practitioner physicians. The device involves a 20-60 minute in-office application of a helmet with electrodes that supposedly tests certain brain functions.

During the company's initial startup phase, the psychologist selected six billing codes for the eVox device. The settlement resolves allegations that from January 1, 2013, through May 31, 2021, the company and he promoted to other healthcare providers six false billing codes for Medicare reimbursement for the eVox device.

The United States asserted that none of the codes were ever appropriate for the eVox device as applied because the codes generally require a longer testing time, a specialized environment (e.g., soundproof/dark room), and can only be administered by a relevant specialist.

Moreover, the United States contended that the company and he improperly encouraged healthcare providers to bill multiple codes for a single application of the eVox device.

In 2018, coding consultants informed the company that many of the billing codes it was promoting were problematic, after which time the company stopped promoting the false codes.

This settlement resolves claims originally brought by a couple, to whom, among others, the company marketed the eVox system. The case was brought under the whistleblower, or qui tam, provisions of the False Claims Act. The Act permits private citizens with knowledge of fraud against the government to bring a lawsuit on behalf of the United States and to share in any recovery. They will receive $89,000 of the settlement proceeds.

The U.S. Attorney on the case stated, "There is no 'startup' exception under the False Claims Act," "You will be held accountable if you knowingly promote false billing codes to others."

All civil claims are allegations only. There has been no determination of civil liability.

Read more about this case at www.justice.gov.

Justice Department Announcing the Results of a Nationwide COVID-19 Fraud Enforcement Action

In late August, the Justice Department announced the results of a coordinated, nationwide enforcement action to combat COVID-19 fraud, which included 718 enforcement actions – including federal criminal charges against 371 defendants – for offenses related to over $836 million in alleged COVID-19 fraud.

There was a three-month coordinated law enforcement action that took place from May 2023 through July 2023, which included criminal, civil, and forfeiture actions.

Many of the cases in the enforcement action involve charges related to pandemic unemployment insurance benefit fraud and fraud against the two largest pandemic Small Business Administration programs: the Paycheck Protection Program and Economic Injury Disaster Loans.

Additional matters involved pandemic healthcare billing fraud, fraud against the Emergency Rental Assistance program, and fraud committed against the IRS Employee Retention Credit program (ERC), a refundable tax credit for businesses and tax-exempt organizations that had employees and were affected during

the COVID-19 pandemic.

IRS Criminal Investigations worked with the California Strike Force and the U.S. Attorney's Office for the District of New Jersey to bring multimillion dollar ERC fraud cases during the enforcement action.

Read additional details at www.justice.gov.

Imperial Valley Doctor Admits Using Unapproved Cosmetic Drugs for Years

A California doctor pleaded guilty to crimes related to his years-long use of foreign, unapproved, and misbranded cosmetic drugs.

He pleaded guilty to receipt of misbranded drugs in interstate commerce and being an accessory after the fact to an accomplice, who smuggled the unapproved drugs into the United States from Mexico.

In his plea agreement, he admitted that none of the injectable botulinum toxin or lip fillers used by his clinics between November 2016 and October 2020 was approved for use in the United States.

This specifically included a botulinum toxin product called "Xeomeen" and an injectable lip filler called Probcel—both products that have not been approved by the U.S. Food and Drug Administration.

He acknowledged that he received $100,767 in gross receipts for almost four years of cosmetic services performed with unapproved drugs and devices.

As part of his plea agreement, he has agreed to forfeit that amount, and to pay a fine of $201,534.

He also agreed to pay restitution to victims of his offense.

In his plea agreement, he admitted purchasing most of his unapproved drugs and devices from the operator of a "med spa" in Mexicali, Mexico, who smuggled them into the United States without declaring them.

A Special Agent in Charge on the case stated, "Injecting unapproved medicines poses a significant threat to public health and can have serious consequences for individuals."

Read further information about this case at www.justice.gov.

Michigan Doctor to Pay $6.5 Million to Resolve False Claims Act Allegations

A Michigan interventional pain management specialist and two medical entities that he owned and operated have agreed to pay $6,500,000 to resolve claims that they violated the federal False Claims Act. The settlement resolves allegations that from January 1, 2015, to December 31, 2018, they billed Medicare and Medicaid for excessive and medically unnecessary presumptive and definitive urine drug tests that were not relevant to their patients' diagnosis or treatment, along with additional laboratory charges that were not separately billable with the urine drug tests.

Additionally, the man and his entities are alleged to have billed Medicare and Medicaid for medically unnecessary moderate sedation services that were routinely performed in conjunction with interventional pain management procedures that did not require moderate sedation services. The government also alleged that they frequently charged Medicare and Medicaid for expensive back braces that were medically unnecessary or otherwise ineligible for reimbursement.

The civil settlement included the resolution of claims in two separate lawsuits brought by relators under the qui tam or whistleblower provisions of the False Claims Act. Under these provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. As part of the settlement, the relators will receive a combined payment in the amount of $1,267,500.

Read the specifics of this case at www.justice.gov.

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She has served as a multi-specialty healthcare coding, auditing, and compliance professional in the industry for over 12 years. She began her second career as a medical biller and continued to advance into a renowned cancer hospital's patient business services' department in Houston, Texas. Since then, she has had the honor of directly working with and supporting healthcare attorneys in defense of their clients' myriad of reimbursement issues for almost six years.

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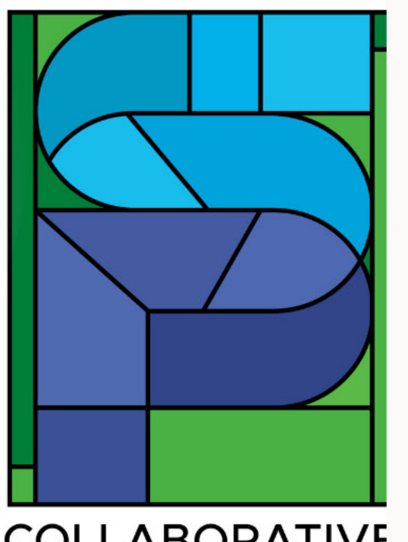

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Choosing the Right Deductible

Often and easily forgotten is that the producer's role extends beyond simply selling insurance policies. Top shelf producers are trusted advisors not only to their clients, but carrier partners, as well. This article will focus on serving the employer. In this capacity, the producer may act as an extension of the employer's HR, finance, and executive departments. This may include advising on industry trends, policy updates, and emerging healthcare issues.

The ultimate goal is to strike a balance between cost and coverage, ensuring that employers have the financial protection they need while managing their healthcare expenses. By considering each employer's unique circumstances and priorities, ideally the producer will guide them toward an optimal deductible choice that meets their healthcare and financial needs. This includes understanding balance and trade-offs between premiums vs deductibles, cash flow vs fixed cost, and controlling the outcome via customization vs template.

Variables for an employer to consider assisting in the decision-making process include premium affordability, financial capability, current health conditions and loss experience, risk tolerance, and control.

Premium Affordability

What is the employer's ability to pay insurance premiums? Higher deductibles often come with lower premium costs, providing more affordable coverage, but the employer must be able to fund the deductible. Employers must carefully weigh the balance between premium expenses and potential out-of-pocket costs.

Financial Capability

An employer must assess their financial situation – current and future. They should evaluate their assets, cash flows, and reserve funds, as well as their short and long-term liabilities to gauge their ability to cover higher deductible amounts in the event of a medical claim. Striking a balance between affordability and financial security is essential, especially when it comes to the attachment point.

Current Health Conditions and Loss Experience

The employer's current health conditions and historical

loss experience may influence their deductible selection. An employer with healthier individuals may consider higher deductibles as they anticipate fewer medical visits and lower overall costs. Unfortunately, when an employer is expected to have a poor policy year and/or challenged loss experience, they often attempt to soften their exposures by reducing the deductible. A common solution is to apply specific claimant lasers. Or they attempt to soften their exposures by pushing down premiums; however, increasing the deductible may help alleviate the premium burden and guards against leveraged trend.

Risk Tolerance

An employer must weigh their risk tolerance in determining the right deductible. Some employers prefer lower deductibles, which provide predictability in out-of-pocket expenses, but often come with higher premium costs and unpredictable renewals. Others may be comfortable with higher deductibles, accepting a greater financial risk in exchange for lower premiums.

Control

Lastly, the degree the employer wants to control the outcome with risk management, claims management, cost containment/bill utilization, and employing other risk transfer vehicles (such as organ transplant carve outs, RX management, etc.) are also determining factors to selecting the appropriate deductible.

Conclusion

So why is this important? It's possible that many employers have not fully weighed all the variables noted, which may cause them to seek out the cheapest and easiest route. Understanding how self-funding (aka self-insuring) can play an integral part to strengthening an employer's insurance coverage and possibly leveraging their financial advantage. Granted, self-insuring becomes more attractive to larger employers or those with strong financials to capitalize on this financial tool as compared to a fully insured product.

As producers, your expertise and guidance are invaluable in helping employers make well-informed decisions that align with their goals and provide them with the necessary coverage and financial protection.

Deborah Dore is a senior underwriter at USBenefits Insurance Services. USBenefits Insurance Services, LLC dba Employer Stop Loss Insurance Services, LLC (USB) is a full service Managing General Underwriter. They officially launched in July of 2007. Their founding members believed that to be successful, understanding their clients' current and future needs comes first. For more information, contact http://www.usbstoploss.

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Whistleblowers and Company Data: To Collect or Not to Collect

Before the thought, "Oh, I have access to all this information – 'Come on Barbie, let's go party' [1]" crosses a potential whistleblower's mind, there is one question to ask. "Should I collect documents from my employer or a person that I contract with to perform services?" This is critical to avoiding potential liability at both the employment and post-employment stages. What are the potential ramifications? It depends.

First, let's address post-employment access to documents. Simply stated, don't attempt to log into one's former email, databases, social media, or any other stored data or communication. Title II of the Electronic Communications Protection Act (ECPA), the Stored Communications Act, 18 U.S.C. §§ 2701-12 (SCA), protects certain electronically stored communications.[2] Simply stated, it is criminal. The SCA and ECPA apply to both employers[3] and employees alike.[4]

Workforce members, especially former workforce members, should be aware of the law and potential consequences of not abiding by the law. United States v. Szymuszkiewicz, 622 F.3d 701 (7th Cir. 2010) is one example. Specifically, the Court of Appeals for the Seventh Circuit noted that the workforce member was allegedly:

> *...monitor[ing] email messages sent to his supervisor, Nella Infusino. She found out by accident when being trained to use Microsoft Outlook, her email client. She discovered a "rule" that directed Outlook to forward to Szymuszkiewicz all messages she received. Szymuszkiewicz was convicted under the Wiretap Act for intentionally intercepting an electronic communi-*

cation … agents found emails to Infusino stored in a personal folder of Szymuszkiewicz's Outlook client—in other words, Szymuszkiewicz not only received the emails but also moved them from his inbox to a separate folder for retention—which is not what would have happened had all of Szymuszkiewicz's access been legitimate…The jury could have chosen to believe Szymuszkiewicz's contention that he received Infusino's emails legitimately, or by mistake, but the evidence supported the more sinister inference that he obtained them intentionally and without her knowledge (622 F.3d at 703-4; internal citations omitted).

Bottom line: If an individual is a former workforce member, don't attempt to or actually access the information stored on a former employer's or contractor's hardware, software, or cloud services.[5] Having text messages on one's phone or email that was not wiped by the company on one's personal phone needs to be discussed with an attorney and/or the government and handled accordingly.

Choosing an attorney is equally important; some general guidelines are as follows:

1. Is the attorney knowledgeable about whistleblower matters?
2. If there is potential criminal liability, is the attorney qualified to handle the nuances, or alternatively, are they willing to partner with a criminal lawyer to effectuate the client's best interests?
3. Is there a "fit" between the client and the attorney(s)?

Contacting knowledgeable counsel can assist a potential whistleblower in avoiding landmines and navigating a complicated process from the outset instead of having to be reactive.

The remainder of this article addresses the following items:

- The interference ban on thwarting whistleblowers from bringing fraud that is violative of the False Claims Act and/or the Dodd-Frank Act to the respective government agencies
- Protection basics afforded to whistleblowers and certain documents as a matter of public policy,[6] as well as under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Defend Trade Secrets Act of 2016 (DTSA)[7]
- The nuance in Colorado's False Claims Act

The "Interference Ban" on Reporting Fraud to the Government

The FCA "has been used more than any other [statute] in defending the federal treasury against unscrupulous contractors and grantees."[8] A civil action alleging 31 U.S.C. § 3729 violations may commence in one of two ways: (1) the government may initiate the action;[9] or (2) a private person ("relator"), who is represented by a licensed attorney, may bring a qui tam civil "for the person and for the United States Government."[10] 31 U.S.C. § 3730(h) is the anti-retaliation provision of the FCA, which states:

> *Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against the terms and conditions of employment because of lawful acts by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop one or more violations of this subchapter.*[11]

As the Sixth Circuit Court of Appeals proffered, "The FCA is designed to discourage fraud against the government, and the purpose of the Act's anti-retaliation provision is to encourage the reporting of fraud and facilitate the federal government's ability to stymie crime by protect[ing] persons who assist [in its] discovery and prosecution."[12] There are limitations to the types of information, the use of the information, and the balancing of bringing allegations of fraud and the related evidence to the attention of a state or federal government agency and other laws and policy considerations such as contract law.

Procuring Information – Public Policy & Legal Exceptions

As a matter of public policy, as the United States Supreme Court articulated in Town of Newton v. Rumery, there is a balance between the "public interest in having information brought forward that the government could not otherwise obtain [with the public interest in] encouraging parties to settle disputes."[13] In addition to the balancing of public policy interests, there are laws that contain "whistleblower exceptions" for persons who have a good faith basis for taking items for the purpose of bringing them to an attorney and/or to a government agency. Three such legal provisions are the HIPAA exception,[14] the DTSA exception,[15] and the U.S. Securities and Exchange Commission (SEC) Rule 21F-17(a) of the Dodd Frank Wall Street Reform and

Consumer Protection Act ("Dodd-Frank"), which amended Section 21F of the Securities Exchange Act of 1934 ("Exchange Act").[16] Each legal exception appears below:

- **HIPAA Exception (45 C.F.R. §164.502(j)(1) –** Provides two exceptions whereby a workforce member or business associate discloses information, including protected health information – (i) The workforce member or business associate believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public; and (ii) the disclosure is to: (A) a health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate healthcare accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity; *or* (B) an attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to the conduct described in paragraph (j)(1)(i) of this section (emphasis added).[17]
- **DTSA Exception (18 U.S.C. § 1833) –** Provides two instances where an individual may utilize documents containing trade secrets – (1) if the information is to either an attorney or, directly or indirectly, to a "federal, state, or local government official"; and (2) an anti-retaliation lawsuit. This exception also requires that this information be filed under seal.[18]
- **Rule 21F-17(a) -** "No person may take action to impede an individual from communicating directly with the Commission staff about a possible securities law violation, including enforcing, or threatening to enforce, a confidentiality agreement…with respect to such communications."[19]

An exception that both whistleblowers and their counsel should take note of is the general rule that attorney-client privileged documents should not be utilized.[20] If counsel is unfamiliar with how the government addresses attorney-client privileged documents, then outside counsel with experience in this area should be consulted, including if there is a potential for addressing the crime-fraud exception.[21] Whistleblowers should alert their counsel if they have this type of information in their possession, but they should not provide it directly to them.

Colorado's Nuance

Colorado has two distinct laws which enable whistleblowers to file a qui tam action when they have knowledge of state law violations. Specifically, the Colorado False Claims Act (CO FCA)[22] and the Medicaid False Claims Act (MFCA) are the two avenues that persons can pursue. At its core, the CO FCA imposes liability on persons who knowingly present false or fraudulent claims for payment to the state, misappropriate state property, or deceptively avoid binding obligations to pay the state, just to name a few.[23] By way of contrast, the MFCA imparts liability on persons who knowingly submit false claims to Colorado's medical assistance programs, which includes Medicaid.

While there are nuances between the FCA and the Colorado laws, one notable distinction is that the CO FCA expressly mentions "confidential information" in relation to a retaliation claim. Specifically, Section (8)(a)(I):

> *(a) As used in this subsection (8), unless the context otherwise requires:*
> *(I) "Confidential information" includes documents, e-mails and other electronic data, medical records,*

Ms. Rose has been consecutively named to the National Women's Trial Lawyers Association - Top 25, National Trial Lawyers Top 100, Houstonia Magazine's Top Lawyers in Healthcare Law, and the Texas Bar College.

> *financial records, trade secret information, intellectual property, or information that is subject to an employment agreement, confidentiality agreement, or nondisclosure agreement or for which the person who brought the action pursuant to subsection (3) of this section has a fiduciary obligation to maintain as confidential.* ***Confidential information does not include information that is protected by the defendant's attorney-client privilege unless the privilege was waived, inadvertently or otherwise, by the person who holds the privilege; an exception to the privilege applies; or disclosure of the information is permitted by an attorney pursuant to 17 CFR 205.3 (d)(2), the applicable Colorado rules of professional conduct, or otherwise (emphasis added).***

Whistleblowers and counsel should appreciate the nuances, which may be express or implied, between state and federal whistleblower laws.

Conclusion

Whistleblowers play a vital role in combatting fraud and returning money to the federal and the state fiscs. As Senator Charles Grassley recently remarked during the 10th anniversary of National Whistleblower Appreciation Day, "We're here to recognize the contributions and sacrifices that whistleblowers make every day for our country, the country you love."[24] As this article illustrates, the FCA and state anti-fraud laws are complicated. Regarding evidence, whistleblowers should be aware of the consequences post-employment, as well as only accessing information that relates to their potential case and that is within the scope of their employment. Choosing a knowledgeable attorney is also critical to navigating the various state and federal laws, as well as evidentiary and procedural issues. In sum, there are often exceptions; however, certain actions, such as accessing electronic databases post-employment offer less wiggle room.

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Truly Autonomous Coding Requires a Multifaceted Solution

Coding technology has come a long way since the days when Computer-Assisted Coding (CAC) was a bleeding edge feature of the more advanced encoder solutions. Today's CAC solutions are often integrated with Clinical Documentation Integrity (CDI) tools and have automated much of the coding process. Enhanced with Artificial Intelligence (AI) combining Natural Language Processing (NLP) with knowledge graphs and a wide variety of system learning techniques, today's CAC solutions are capable of reading different types of data from within the patient's EHR chart and propose the most relevant codes. Coders need only accept or decline proposed codes.

It is a level of automation that has delivered upon its promise of greater efficiency, accuracy, and productivity. Over time, these systems mature and start generating ready-to-bill encounters, leading further toward what is now known as autonomous coding.

For many provider organizations, the lure of autonomous coding technology is the idea that it functions independently of any human intervention. The reality, however, is that autonomous coding tools have varying levels of autonomy and varying degrees of success, depending on a variety of factors including documentation quality, clarity of guidelines, variation from specialty to specialty, and most importantly, the ability of the AI to learn and adapt to the variables that are part of the coding process.

Organizations that are unfortunate enough to come to this understanding late in their selection process may find themselves faced with engaging a second or even third technology or service vendor to close the gaps –

bringing with them the headaches and inconsistencies that can come with managing multiple vendors.

Understanding the reality and limitations of autonomous coding will go a long way toward protecting any investments made into the coding solution and optimizing the value it brings to the organization.

The Current State

Coding has historically involved multiple human touchpoints that leave room for a margin of error. While advances in CAC have reaped significant improvements in accuracy, the emergence of AI has taken it even farther by allowing coders to pull away from many aspects of the coding process and focus instead on validation and auditing. Specifically, the speed and accuracy of autonomous coding make it an ideal solution for healthcare organizations constrained by labor shortages or those looking to reassign team members toward more value-added tasks or functions.

Autonomous coding may leverage ML, NLP, clinical language understanding (CLU), computational linguistics, knowledge graphs, large language models (LLMs), and advanced algorithms to analyze, interpret, and classify large volumes of patient data, including patient records, physician notes, lab reports, and diagnostic information. This enables the AI to accurately and efficiently assign diagnosis and procedure codes, thereby freeing its human counterparts to focus on higher complexity charts and providing the feedback that is critical to AI's ongoing education and adaptation.

For example, NLP and CLU can extract relevant information from physician notes and other unstructured textual data and combine this with structured data to identify and capture vital medical concepts, procedures, and diagnoses. ML modes can be trained to predict the appropriate codes for new, unseen records based on patterns and associations, helping identify relationships between medical concepts, diagnoses, and procedures. Importantly, these algorithms can continue learning with an effective feedback loop infusing human knowledge and intelligence, increasing their level of accuracy over time.

There are numerous benefits to using autonomous coding. Early adopters have reported:

- A 50% decrease in coding costs
- 3-5 fewer A/R days or DNFC
- A 25%-50% reduction in coding related denials
- A 50% decrease in FTEs

These systems are fast, consistent, cost-effective, and scalable, and deliver increased efficiency and improved compliance. However, autonomous coding has its limitations.

Reality Check

One of the biggest limitations is what autonomous coding cannot yet do, which is code 100% of a healthcare organization's census. Because autonomous coding is limited to areas with a lot of repetition and is negatively impacted by variability in data, only specific specialties like radiology and ED have achieved high levels of automation.

Autonomous coding also does not automate the abstraction of additional parameters, for example, as required by the Merit-Based Incentive Payment System (MIPS), requiring yet another vendor or additional technology tools to manage these abstractions in-house. It is also not possible for prospective (pre-bill) audits to be undertaken via autonomous coding. As such, organizations utilizing autonomous coding will require multiple other vendors to fill in the gaps. They will also require coding support tools like CAC, CDI, and encoders to manage the coding of low-confidence charts.

Finally, because the autonomous coding solution may not integrate with those other tools, processes could end up siloed across CDI, facility and professional fee coding, audits, quality, and compliance. This means not only are there multiple vendors to manage, but there is also no means for consolidating reporting.

Thus, when we zoom out to see the big picture, it's clear that today's autonomous coding technologies are not truly autonomous.

It is a problem that exists because autonomous coding solutions are AI-based and therefore require access to a massive and comprehensive body of quality data to be properly and accurately trained. That data must also flow continuously for the system to learn and algorithms to mature – continuous learning that requires the human touch in the form of feedback and corrections.

Other issues placing limits on today's autonomous coding solutions include:

- The subjective nature of coding, which uses guidelines that are not always black and white and are open to interpretation by the human coder.
- Disparate systems used for overflow coding and auditing limit the feedback loop, in turn limiting the AI system's ability to learn.
- Vendors who focus solely on autonomous coding solutions and therefore lack the foundational knowledge derived from work in key areas like CAC and CDI, which impacts the quality of training.

The good news is that AI is always improving; if you give it the right data and training, autonomous coding technology will continue moving closer to being truly autonomous. Until then, when implemented to address specific scenarios – for example to alleviate physician burnout or perform coding for a specific specialty – autonomous coding in its current level of maturation will still deliver significant value.

Making the Right Investment

Once the decision is made to proceed with integrating autonomous coding into an organization's overall coding strategy, the next step is to identify the best vendor to meet all the organization's needs. Look for one that can provide a truly autonomous coding solution with both the technology tools and technology-enabled services integrated on one platform and under one roof.

The best way to identify the right vendor fit is by answering the following questions:

- What is the objective of implementing autonomous coding? For example, is the goal to address cost, physician burnout, coding audits and quality, staffing, or vendor issues?
- What are the current audit processes?
- How much automation is required to realize value? Is partial automation or single-specialty automation sufficient?
- Will other systems such as an encoder, CAC, CDI, etc. still be required? And if so, how will they be managed and at what price?
- Will other vendors be required to provide other coding services?

Finally, will those multiple systems and/or vendors reside on the same platform and therefore be able to contribute to training the autonomous coding AI? If so, they can become part of the overall transition plan to move from assisted to autonomous in a staged migration.

For organizations that have set appropriate expectations and understand the true value that can be delivered, autonomous coding holds great promise for transforming labor-intensive and error-prone coding processes and creating new opportunities for revenue growth. As more providers adopt autonomous coding, its growth and maturation into a truly autonomous solution will be accelerated, paving the way for streamlined operations, improved financial outcomes, and, most importantly, a better patient experience.

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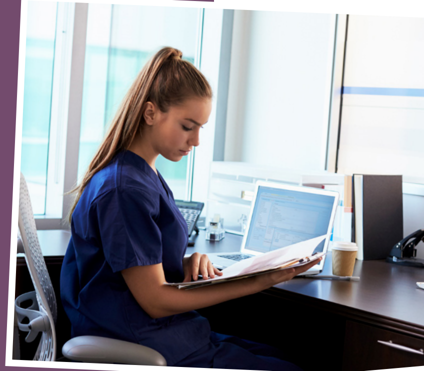

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The American Healthcare System:
A Problem in Need of Solutions

The United States spends more on healthcare than any other country in the world, yet it has some of the worst health outcomes. This is due in part to a number of problems with the American healthcare system, including:

- **High costs -** The cost of healthcare in the United States is astronomical. In 2022, according to the Kaiser Family Foundation, the average American family spent $22,463 on healthcare. This includes premiums, copays, and out-of-pocket expenses. The high cost of healthcare is a major barrier to access, and it can lead to financial hardship or bankruptcy for many families.
- **Inequality in access -** Not everyone in the United States has access to quality healthcare. Millions of Americans are uninsured or underinsured, and they may not be able to afford the care they need. This is especially true for people of color, people with disabilities, and people who live in rural areas. According to the National Rural Health Association, one third of rural hospitals in the United States are at risk of closing.
- **A fragmented system -** The American healthcare system is fragmented, with multiple payers, providers, and regulators. This makes it difficult to coordinate care, and it can lead to errors and delays.
- **A lack of transparency -** It can be difficult to know what healthcare services will cost, and this can make it difficult to make informed decisions about care. Or lead to people delaying care until they face a medical emergency.
- **A focus on profits -** The American healthcare system is driven by profits, and this can lead to decisions that are not in the best interests of patients. For example, hospitals may be more likely to perform unnecessary procedures if they are more profitable.

These are just some of the problems with the American

healthcare system. These problems have a significant impact on the health and well-being of Americans, and they need to be addressed.

There are a number of potential solutions to the problems with the American healthcare system. Some of these solutions include:

- **Universal healthcare -** Universal healthcare would guarantee that everyone in the United States has access to quality healthcare, regardless of their income or employment status.
- **Medicare for All -** Medicare for All is a single-payer healthcare system that would replace private health insurance with a government-run plan. This would eliminate the profit motive from the healthcare system and make it more affordable for everyone. Only 43 other countries successfully offer universal healthcare systems for at least 90 percent of their populations.
- **Healthcare reform -** Healthcare reform could address some of the problems with the current system, such as high costs and lack of access. This could include measures such as expanding Medicaid, regulating the pharmaceutical industry, and making healthcare more transparent.

The problems with the American healthcare system are complex, but there are a number of potential solutions. It is important to continue to discuss and debate these solutions so that we can find a way to improve the healthcare system for all Americans.

In addition to the problems mentioned above, the American healthcare system also faces a number of other challenges, such as:

- **An aging population -** The United States is facing an aging population, and this is putting a strain on the healthcare system. Over 25 percent of the United States' total population is eligible for Medicare. Older adults are more likely to have chronic health conditions, and they require more costly care.
- **The rise of chronic diseases -** Chronic diseases, such as heart disease, cancer, and diabetes, are on the rise in the United States. These diseases are costly to treat, and they can lead to disability and death.
- **The shortage of healthcare providers -** There is a shortage of healthcare providers in the United States, particularly in rural areas. This shortage makes it difficult for people to get the care they need, especially if they live in rural areas.

These challenges are only going to get worse in the coming years. It is important to start addressing these challenges now so we can ensure that the American healthcare system is sustainable in the long term.

The future of the American healthcare system is uncertain. However, if we are able to address the problems that the system faces, we can create a system that is affordable, accessible, and equitable for all Americans.

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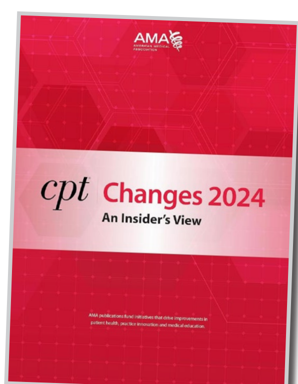

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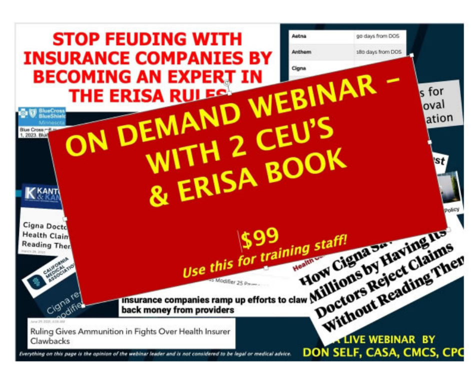

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