# Chapter 1. Legal and Ethical Issues

## Learning Outcomes

1.1 Identify your responsibilities under HIPAA’s Privacy Rule to protect a patient’s information.

1.2 Elaborate on the purpose of the Health Care Fraud and Abuse Control Program.

1.3 Analyze the use of the National Correct Coding Initiative.

1.4 Apply the rules of ethical and legal coding.

1.5 Identify the points within industry codes of ethics that will direct your conduct as a professional coder.

1.6 Outline the purpose of a compliance program.

Chapter Outline

Learning Outcomes

Key Terms

What Is It?

Health Insurance Portability and Accountability Act

 Who Is Responsible For Obeying This Law?

 What This Law Covers

 The Use and Disclosure of PHI

 Getting Written Approval

 Permitted Uses and Disclosures

 Privacy Notices

 Violating HIPAA’s Privacy Rule

 Civil Penalties

 Criminal Penalties

Health Care Fraud and Abuse Control Program

National Correct Coding Initiative

Federal False Claims Act

Rules for Ethical and Legal Coding

Codes of Ethics

 American Health Information Management Association Code of Ethics

 AAPC Code of Ethical Standards

Compliance Programs

Chapter Summary

Chapter 1 Review

 Using Terminology

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## Chapter Overview

As health care professionals, you will have special legal and ethical responsibilities that others, working in a standard business office, do not have. You will have the privilege to work with other health care professionals to help their patients and clients. In order to do this properly, you will have to have access to very personal and private information about that individual. In addition, as an insurance coding specialist, you will be working with data that also directly relates to how much your facility will be paid for its services; this is called reimbursement. As you can imagine, working with these two categories of information: personal information about an individual’s health; and how much professionals are being paid for their services, involve confidentiality, honesty, and accuracy. Try to encourage them to look at the healthcare environment from the perspective of a medical professional. How would their concept of the situation change given the new perspective?

Legal and ethical issues can be very complicated. Some working professionals are misinformed. Others have not had the opportunity to learn the proper way to handle certain situations. This chapter is written to help you establish a firm foundation for your future career.

## Chapter Discussion Activities

### HIPAA [Learning Outcome: 1.1]

1. Think about the experiences in a healthcare facility you may have had or read about, or those of someone you know.
2. Relate to your classmates, an experience relating to HIPAA, either the upholding of the terms of the Privacy Rule, or in violation of the Privacy Rule.
3. Include new perspective on this situation now that you understand HIPAA. If it was a negative experience, what would you do differently?

I have had students relate experiences of picking up x-rays or medical records for relatives without being asked to show identification. Also, some students may relate stories of circumstances where they were prevented from getting information because staff were complying with the law. This is a great opportunity to help them get better perspective: what if they were not who they claimed to be; an old boyfriend/girlfriend or a co-worker trying to get the individual fired using health information, etc. Protection benefits everyone. You might ask them if there was ever a time when the student had a health issue or concern that he or she did not want even one person in the world to know.

### Ethics & Legalities [Learning Outcomes: 1.4 and 1.5]

### Pick ONE of these scenarios and explain what you would do if you were to encounter this situation on the job.

1. The patient's chart notes that Dr. Johnson gave the five-year-old girl her MMR vaccine. Your office manager tells you to code each of the sera separately: using a different code for the Measles, the Mumps, and the Rubella instead of the one combination code because the office will get more money. She tells you that it can't be fraud because it is the truth; the doctor did give her all three vaccines.

One analogy that most students can relate to involves the comparison of going to a fast food restaurant and purchasing the combo meal that is always offered for less money than the purchase of the burger, fries, and drink separately. Would your students want to pay the higher price? Why should the insurance company pay more? In addition, point out that the combination vaccine uses fewer resources with only one alcohol swab, one syringe, and one action by the nurse. Why should three times the resources be paid for when the extra material was not used?

1. You open a chart to code it for reimbursement. On the face sheet or the Superbill, you notice that Dr. Cipher has indicated that the procedure provided to the patient as: Flu Shot. However, you know for a fact that your office has no more flu vaccine and is not expecting a shipment until tomorrow.

Not only is this illegal, it can create a very dangerous situation because the documentation states he or she is protected when in fact they are not. This can be life-threatening if the patient is in an at-risk population. Students should discuss what to do from the point of view that the physician made a human error (did this once or twice) as well as what to do when fraudulent behavior is identified (doing this time and time again).

Actual Cases from the Office of the Inspector General ([www.oig.hhs.gov](http://www.oig.hhs.gov))

[Learning Outcomes: 1.2 and 1.6]

1. In Ohio, a former owner of a home health agency was sentenced to 97 months in prison and ordered to pay $2.7 million in restitution pursuant to her conviction for her scheme to defraud the Government. The investigation revealed that from October 2001 through May 2003, Medicaid was billed for skilled nursing services that were not rendered as claimed. The woman billed for 14 hours of services per week when actually only 1 hour or less of services was provided per week. During the trial, it was also revealed that the woman instructed employees to falsify nursing notes.
2. In Washington D.C., a doctor was sentenced to 5 months incarceration and ordered to pay $155,000 in restitution for health care fraud. From October 2001 through March 2003, the doctor submitted claims to Medicare for Reteplase injections that were not given. Reteplase is a drug generally given in a hospital emergency room within the first three hours of a patient experiencing myocardial infarction (commonly referred to as a “heart attack”). The doctor submitted claims for one patient who purportedly had been injected 119 times.
3. In Illinois, a licensed speech-language pathologist was sentenced to 6 months home detention and ordered to pay $60,000 in restitution for health care fraud. From January 2001 to September 2002, the speech-language pathologist billed the Medicaid program for services that were not provided. The investigation revealed that the woman altered or caused to be altered records to reflect therapy services that were not provided.
4. In Tennessee, the owner of a Texas durable medical equipment supplier was sentenced to 18 months in prison and ordered to pay $432,000 in restitution for violating the anti-kickback statute. Investigation revealed that the owner paid kickbacks of $1,000 for each certificate of medical necessity (CMN) she received. The CMNs were then used to bill Medicare for motorized wheelchairs for patients who had no need for the wheelchair. Patients either received no wheelchair at all or were provided with a less expensive scooter.
5. In Michigan, an attorney specializing in health care law was sentenced to 13 months incarceration and ordered to pay $98,000 in restitution for mail fraud. The attorney was hired by a physician group to negotiate a contractual joint venture agreement with a physical therapy company. As part of the negotiations, he was tasked with obtaining an official advisory opinion from OIG to ensure that the arrangement would not violate the anti-kickback statute. However, he did not request and obtain an advisory opinion from OIG but instead prepared false documents on copied OIG letterhead which falsely stated the joint venture met with the approval of OIG.
6. In Virginia, a personal care aide, who devised a scheme to defraud the Medicaid program, was sentenced to 5 months in jail and ordered to pay $58,000 in joint and several restitution. Three co-defendants were previously sentenced for their involvement in the fraud scheme and held jointly liable for the restitution amount. The personal care aides caused the Medicaid program to pay for services not rendered by falsifying time sheets and personal care aide logs.

### Actual Cases From the Internal Revenue Service (www.irs.gov)

[Learning Outcome: 1.4]

1. On March 8, 2007, in Tyler, TX, Artis Anderson was sentenced to 24 months in federal prison and ordered to pay $828,092 in restitution for federal health care fraud violations and engaging in monetary transactions with property derived from specified unlawful activity. Anderson pleaded guilty to the charges on December 8, 2005. According to information presented in court, Anderson helped durable medical equipment providers in Houston, TX to submit fraudulent Medicare claims for motorized wheelchair and scooter reimbursement. He later opened a medical equipment business in Gregg County, TX and submitted fraudulent claims for motorized wheelchairs to Medicare.

## Additional Resources

Health Care Fraud and Abuse Control Program: [www.gao.gov](http://www.gao.gov)

Qui Tam Lawsuits (The Whistleblower Statute): [www.dhhs.gov](http://www.dhhs.gov)

The Joint Commission: [www.jointcommission.org](http://www.jointcommission.org)

Office of Civil Rights (HIPAA): [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa)

Medicaid Fraud Control Unit: <http://oig.hhs.gov/publications/mfcu.html>

National Correct Coding Initiative: [www.cms.hhs.gov/NationalCorrectCodInitEd/](http://www.cms.hhs.gov/NationalCorrectCodInitEd/)

Federal Register: [www.gpoaccess.gov/fr/index.html](http://www.gpoaccess.gov/fr/index.html)

Health Care Law: H.R.3590—Patient Protection and Affordable Care Act (March 23, 2010):

 <http://www.opencongress.org/bill/111-h3590/show>

Health Care Law News: Understanding the New Healthcare Law:

 <http://www.healthcare.gov/law/introduction/index.html>

HIPAA Violation: 27 Suspended for Clooney File Peek: <http://www.cnn.com/2007/SHOWBIZ/10/10/clooney.records/index.html>

## Chapter 1 Review Answer Key

**Using Terminology**

Learning Outcomes: 1.1 and 1.4

1. I
2. H
3. B
4. C
5. F
6. M
7. L
8. J
9. K
10. D
11. A
12. E
13. G

**Checking Your Understanding**

Learning Outcomes: 1.1, 1.2, and 1.4

1. C
2. B
3. A
4. B
5. C
6. A
7. D
8. C
9. A
10. B
11. C
12. A
13. D
14. D
15. D
16. C
17. B
18. C
19. D
20. C
21. C
22. B
23. C
24. D
25. C
26. A
27. C
28. D
29. D
30. D

**Applying Your Knowledge**

Learning Outcomes: 1.1, 1.2, 1.3, 1.4, and 1.6

1. What does HIPAA stand for?

Comment: (given as feedback)

HIPAA (pronounced *hip-aah)* stands for the Health Insurance Portability and Accountability Act of 1996.

1. Explain the HIPAA Privacy Rule.

Comment: (given as feedback)

HIPAA’s Privacy Rule is a portion of HIPAA that ensures the availability of patient information for those who should see it while protecting that information from those who should not.

1. Why was the HIPAA Privacy Rule written?

Comment: (given as feedback)

HIPAA’s Privacy Rule was written to protect an individual’s privacy with regard to personal health information, without getting in the way of the flow of data that is necessary to provide appropriate care for that patient. Essentially, the lawmakers tried to make certain that *a patient’s information is easily accessible to those who should have access to it* (such as the physician, insurance coder and biller, and therapist) *and, at the same time, keep it secured against unauthorized people* (such as potential employers, coworkers, or neighborhood gossips) so that they do not see things they have no business seeing.

1. What is the definition of a health care provider?

Comment: (given as feedback)

The definition of a health care provider is any person or organization that gives health care services as the primary business purpose.

1. Discuss health care fraud and why it is important to a professional coding specialist.

Comment: (given as feedback)

**Fraud** is using inaccurate information or other dishonesty to wrongly gain money or other benefit. **Fraud** is something you always want to avoid. As coding specialists, it is our job to explain the entire story of what occurred during an encounter between a healthcare professional and a patient: what happened and why. We interpret the information provided by the professional into a new language—codes—to tell this story. Each code represents something different, with specifics that help you tell this story completely and honestly. If one number is different from the code you should be reporting, you are reporting something different. A professional coding specialist has an obligation; as do all other healthcare professionals, to always participate in **ethical behaviors**. This can sometimes be difficult to understand because most individuals gain their ethical compass from their personal culture, family, and religion.

1. Define and explain PHI.

Comment: (given as feedback)

1. Protected health information (PHI) is any patient-identifiable health information regardless of the form in which it is stored (paper, computer file, etc.). In other words, it is information that anyone could look at and know exactly which individual is being discussed—one specific person. Specific pieces of data are pieces of information related to an individual that must be kept confidential. Discuss the difference between *use* and *disclosure* of PHI.

Comment: (given as feedback)

Use is the sharing of information between people working in the same health care facility for purposes of caring for the patient.

Disclosure is the sharing of information between health care professionals working in separate entities, or facilities, in the course of caring for the patient.

1. What is the National Correct Coding Initiative? Who created it and why was it created? How often is it updated?

Comment: (given as feedback)

The Centers for Medicare and Medicaid Services (CMS) created the National Correct Coding Initiative (NCCI) because reporting the procedures, services, and treatments provided to patients is a complex activity. Accuracy, or lack of accuracy, directly impacts reimbursement to providers and can incorrectly alter health care policies and guidelines as well as misdirect research endeavors. CMS updates their *National Correct Coding Initiative Coding Policy Manual for Medicare Services,* annually; more commonly known as the Coding Policy Manual, on the basis of the coding conventions and guidelines determined by the American Medical Association’s CPT manual, reviews of current coding practices, and accepted industry policies and guidelines. This manual is easily accessible on the CMS website.

1. What is the difference between upcoding and unbundling? Are they permissible practices for a professional coding specialist?

Comment: (given as feedback)

Upcoding is using a code on a claim form that indicates a higher level of service than that which was actually performed and is illegal.

Unbundling is coding individual parts of a specific procedure rather than one combination, or bundle that includes all the components. Unbundling is not permissible.

1. Explain the purpose of a compliance program.

Comment: (given as feedback)

A compliance program will ofﬁcially create policies and procedures; establish the structure to adhere to those policies; set up a monitoring system to ensure that it works; and correct conduct that does not comply. The foundation of the compliance program is the creation of an organizational culture of honesty and compliance with the laws, the discouragement of fraud, waste, and abuse, the discovery of any fraudulent activities as soon as possible using internal policies and audits, and taking immediate corrective action when fraud and abuse do occur.

**You Code It! Application**

Learning Outcomes: 1.1, 1.2, 1.3, 1.4, 1.5, and 1.6

Case 1: Marion Susquehanna

Comment: (given as feedback)

Code the claim honestly and accurately.

Consider the consequences of filing a false claim, including ethical and legal penalties. Also consider the future ramifications of the patient potentially being denied insurance in the future because she “reportedly” had a procedure that may identify a future pre-existing condition.

Case 2: Christopher Marinosci

Comment: (given as feedback)

Query the physician to see if he can provide the needed documentation without appearing to ‘question’ the physician’s authority or knowledge.

Consider the legal and ethical issues involved with documentation: “If it’s not documented, it didn’t happen. If it didn’t happen, you can’t code it.”

Case 3: Joan Kellogg

Comment: (given as feedback)

Do not provide the medical records without the proper authorization. Value privacy over the appearance of convenience: “trust but **verify**”. First, there is no way to know that Felicia is really Joan’s sister. Second, we have no way of knowing the true relationship between these two individuals even if they are sisters. Being a relative does not automatically mean the two people are close and loving. There could be custody issues, inheritance issues, etc.

Case 4: Emily Borner

Comment: (given as feedback)

Do not give out PHI without written authorization on file. Remember that, as healthcare professionals, it is not our place to get involved in the relationships between a patient and anyone else: spouse, parent, child, and sibling. The laws are there to provide support to us to protect our patient and their confidentiality.

Case 5: Allen Granger

Comment: (given as feedback)

Code the claim honestly and accurately with the documentation provided in the chart. If the physician provides documentation showing medical necessity for a deviated septum then you can code it.