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Ethics in CDI

Dawn Valdez, RN, LNC, CDIP, CCDS
CDI Education Specialist
ACDIS at HCPro
Middleton, Massachusetts

hcpro

Presented By

Dawn Valdez, RN, LNC, CDIP, CCDS, is a CDI education specialist for ACDIS at HCPro in Middleton, Massachusetts. Valdez serves as a full-time instructor for the CDI Boot Camps and a subject matter expert for ACDIS. She has more than 25 years of experience in the healthcare industry including in ICU nursing, in legal nurse consulting, and as a nurse manager for a large third-party administrator for which she initiated a nurse audit program. Prior to joining ACDIS, she was a clinical educator and manager of CDI for a large hospital system, where she conducted training, managed CDI staff, performed staff audits, and provided educational classes to both coding and CDI professionals. Valdez has given numerous lectures on healthcare-related topics over the last two decades, including at the national ACDIS conference and a number of ACDIS state chapters. She is a frequent guest on *The ACDIS Podcast* and has had several articles published in *CDI Strategies* as well as HCPro's *JustCoding*.

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - List six ACDIS ethical principles
  - Explain the difference between healthcare *fraud* and healthcare *abuse*

Ethical Principles as a Guide for CDI Practice

ACDIS: Ethical Principles Serves as a Guide

The ACDIS Code of Ethics serves as a guide for the professional behavior of all CDI professionals as well as those who manage the CDI function regardless of the healthcare setting.

It helps CDI professionals identify relevant considerations when professional obligations conflict with ethical standards or when ethical uncertainties arise.

It also serves to orient new CDI practitioners to CDI's mission, values, and ethical principles. It is intended to assist in decision making processes and procedures, outline expectations for making ethical decisions in the workplace and demonstrate a commitment to integrity.

https://acdis.org/resources/acdis-code-ethics

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ACDIS: Ethical Principles Applies to All CDI Professionals

- **The ACDIS Code of Ethics is intended to:**
  - "Assist in decision-making processes and procedures,
  - Outline expectations for making ethical decisions in the workplace, and
  - Demonstrate CDI professionals' commitment to integrity"
- The standards set forth **are relevant to all CDI professionals and those who manage the CDI function,** regardless of the healthcare setting in which they work, or whether they are ACDIS members or nonmembers.
- **CDI professional values are:**
  - "Honesty and integrity
  - Acting in a manner that brings honor to self, peers, and profession
  - Committing to continuing education and lifelong learning"

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ACDIS: Violation of Ethics

Ethical principles should be a part of every organization. **There are several ways in which ethics can be violated which can range from how we treat each other professionally as peers, CDI management staff to becoming involved with white-collar crime.**

White collar crime includes ***medical billing fraud*** as well as ***medical billing abuse*** and has been a long-standing issue within the United States. The **Office of Inspector General (OIG)** have published several investigations involving hospital inpatient claims with findings of large amounts of over-payments and penalties were assessed by extrapolation.

***We will look at examples of healthcare abuse and fraud towards the end of this presentation.**

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Ethical Principle #1

Patient's Right to Privacy

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ACDIS Ethical Principle #1: Privacy Rule

Clinical documentation improvement professionals shall:

- **"Advocate, uphold, and defend the individual's right to privacy and the doctrine of confidentiality in the use and disclosure of information."**
- "Preserve, protect, and secure personal health information in any form or medium and hold in the highest regard the contents of the records and other information of a confidential nature, taking into account the applicable statutes and regulations."

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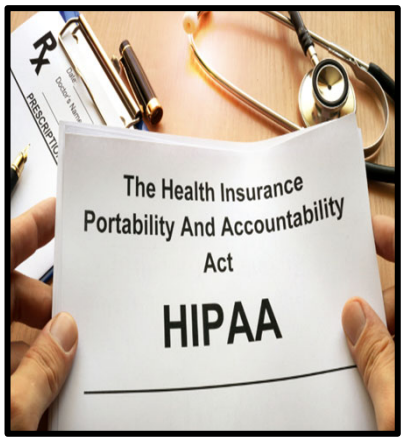
ACDIS Ethical Principle #1: Privacy Rule



The U.S. Department of Health and Human Services ("HHS") issued the **Privacy Rule** to implement the requirement of the **Health Insurance Portability and Accountability Act of 1996** ("HIPAA").

"The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule—called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used."

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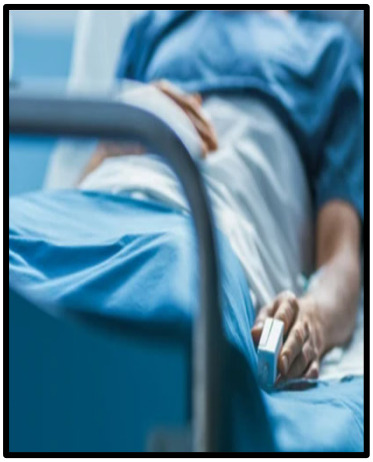
ACDIS Ethical Principle #1 – Case Example

Jenny is a CDIS that is **assigned to the ICU service line** for her cases to review for the current month.

- The CDIS became aware that her neighbor, (whom the CDI is also friends with), has been admitted to the hospital on a **medical/surgical floor.**
- The CDIS "wanted to ensure that the appropriate diagnoses were in her neighbor's chart," so she reviewed the medical record to determine what was going on with the patient.



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Ethical Principle #2

Ethical Professional Behavior

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ACDIS Ethical Principle #2: Professional Behavior

Clinical documentation improvement professionals shall:

"Use only legal and ethical means in all professional dealings, and refuse to cooperate with, or condone by silence, the actions of those who engage in **fraudulent, deceptive, or illegal acts."**

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ACDIS Ethical Principle #2 Case Example

Betty is a CDIS that is known for being very competitive on key performance indicators and strives to be the lead CDIS for financial impact as well as the percentage of queries issued monthly.

- The CDI department has each CDIS reconcile their own financial impact at month end.
- The CDI Manager has discovered several of Betty's cases of reported financial impact were inflated as the diagnoses were appropriately and **consistently documented prior to the queries being submitted.**
- The CDI Manager discusses the findings and because this is not the first warning for Betty and applies the next level of the CDI department disciplinary plan.

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Ethical Principle #3

Respect for All

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ACDIS Ethical Principle #3 Respect for All

Clinical documentation improvement professionals shall:

"Put service and the health and welfare of persons before self-interest and **conduct themselves in the practice of the profession so as to bring honor to themselves, their peers, and the CDI profession**."

"Respect the inherent dignity and worth of every person."

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ACDIS Ethical Principle #3 Case Example

The CDI Manager has a team meeting to discuss behavior patterns that have been reported to H.R. which include **openly gossiping about peers, being rude to CDI staff and openly bullying certain team members by ridiculing the CDIS in front of others.**

- The CDI Manager implemented a **"no tolerance policy" for these types of behaviors.**
- The CDI manager gave a copy of the policy detailing unacceptable behavior to everyone on the team and had everyone sign the document stating they received a copy, which was then filed with the hospital's human resources department.

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Ethical Principle #4

Query When Appropriate

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ACDIS Ethical Principle #4 Identify Appropriate Query Opportunities

Clinical documentation improvement professionals shall:

- "Use queries as a communication tool to improve the quality of health record documentation, **not to inappropriately increase reimbursement or misrepresent quality of care."**
- **"Ensure adequate clinical evidence and/or supportive documentation is noted within the medical record and presented within the associated query**."
- "Follow organizational guidelines and/or current industry and clinical practice guidelines **to identify clinical criteria for support of queries."**

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ACDIS Ethical Principle #4 Case Example – Supportive Clinical Indicators

The CDI Manager asked the Clinical Educator to audit a sample of Joni's cases. **The clinical educator found several of Joni's cases needed a clinical validation query, but query opportunities were missed.**

Upon meeting with Joni, both the clinical educator and CDI manager presented the information with specific cases for Joni to evaluate the audit findings.

- Joni replied that it was her opinion that **the cases in question did not need a CV query.**
  - As the clinical educator began to question Joni about what clinical indicators support certain diagnoses, **Joni revealed that she did not want the negative financial impact that went along with CV queries when the diagnosis was ruled out.**

ACDIS Ethical Principle #4 Query Without Clinical Information

Clinical documentation improvement professionals shall NOT:

- "Query the provider when there is no clinical information in the health record that is prompting the need for a query."
- "Query the provider without identifying and presenting the supporting clinical evidence related to the associated condition within the query."

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ACDIS Ethical Principle #4 – Example Inappropriate Query

Cheryl is a CDIS that is very competitive with her key performance indicators and is "competing" with new hires who are reporting sufficient financial impact per their facilities KPI's. Cheryl submits a query with the following clinical indicators:

4/10 H/P: Pt admitted with Gastritis and dehydration
4/12 MARS: NS IVF 100cc/hr, Shift UOP: none recorded
4/12 VS: HR 102 BP 88/78

Based on the clinical indicators do any of the following apply:
Hypovolemic Shock,
Other, please specify
Clinically Unable to Determine

ACDIS Ethical Principle #4 – Example Inappropriate Query

Cheryl submits a query with the following clinical indicators:

4/10 H/P: Pt admitted with gastritis and **dehydration**

4/11 MARS: **NS IVF 100cc/hr**, Shift Urinary output: **none recorded**

4/12 VS: HR 102 BP **88/78**

Missing: IVF boluses, Vasopressors, Decreasing UOP, Lack of trending of VS, patient positioning

BP Map Calculation:

[SBP + (2 × DBP)]/3

88 + (78 x 2 = 156) = 244/3 = **81.33 (map)**

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Ethical Principle #5

Refuse to Conceal Unethical Practices

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ACDIS Ethical Principle #5 Refuse to Conceal Unethical Practices

- "Act in a professional and ethical manner at all times."
- "Take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues."
- "Be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. These include policies and procedures created by ACDIS, licensing and regulatory bodies, employers, supervisors, agencies, and other professional organizations."

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ACDIS Ethical Principle #5 Case Example – Quality

Jaime is a CDIS who is reviewing a case for which an accidental puncture is identified within the operative report however it's only "one small sentence" and the remainder of the documentation states "no complications" were noted.

- Jaime asks a coworker what he should do because **he really doesn't want to query because the case could trigger a PSI.**
- They decide together that he should not query because it could result in a PSI being triggered and the department has goals of improving the hospitals quality metrics as much as possible.
- They decided to ignore the statement indicating an accidental laceration in the operative report and apply the "consistency" of "no complications" being reported.

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Ethical Principle #6

Advance Specialty Knowledge

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ACDIS Ethical Principle #6 Advance Specialty Knowledge

Clinical documentation improvement professionals shall:

- "Develop and continually enhance their professional expertise, knowledge, and skills through appropriate education, research, training, consultation, and supervision."
- "Base practice decisions on recognized knowledge, including empirically based knowledge relevant to CDI and CDI ethics."

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ACDIS Ethical Principle #6 Advance Specialty Knowledge

The CDI Manager asks John to meet with him to go over his audit findings for the month. The CDI Manager explains that this is the 3rd month in a row of missing query opportunities for clinical validation for sepsis cases which did not demonstrate clinical criteria within the documentation.

Additionally, this CDI specialist was reviewing 6-8 cases per day which is below standard.

John explains that it is the CDI Manager's fault as he has not provided sufficient training on the diagnosis of sepsis and that he hasn't been trained adequately.

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ACDIS Ethical Principles in CDI

General Guidance

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ACDIS Ethical Principles for CDIS – General Information

Clinical documentation integrity professionals shall not:

- "Condone or participate in directing physicians to document only specific diagnoses **and/or to always avoid specific diagnoses, based solely on financial impact."**
- "Query the provider when there is no clinical information in the health record prompting the need for a query."
- "Query the provider without identifying and presenting the supporting clinical evidence related to the associated condition within the query."

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ACDIS Ethical Principles – General Guidance

General Guidance to Follow:

- Sue is a new CDIS. During her orientation, the CDI Manager informs her that because she's a nurse, she has some wiggle room when she speaks to doctors as we encourage verbal queries for that reason. That's the only way to say what we really want to say to providers
- Just record the clinical indicators for the diagnosis and the providers response in the system and you will be fine

ACDIS Ethical Principles – General Guidance

Work Environment:

- "Respect the inherent dignity and worth of every person."
- "Clinical documentation integrity professionals shall treat each person in a respectful fashion, being mindful of individual differences and cultural and ethnic diversity."
- "Promote the value of self-determination for each individual."

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ACDIS Ethical Principles – General Guidance

https://acdis.org/resources/acdis-code-ethics

General Guidance to Follow:

- "Be knowledgeable about organizational policies and procedures for handling concerns about colleagues' unethical behavior."
- "Always conduct their work in a manner that supports and encourages clinicians to use their clinical judgement in identifying the most appropriate diagnoses."
- "Adhere to the official coding guidelines approved by the Cooperating Parties, the CPT rules established by the AMA, and any other official coding rules and guidelines established for use with mandated standard code sets."

ACDIS Ethical Principles – General Guidance

CDI Metrics and Performance:

- "Appropriately research and establish reasonable individual and team performance metrics and key performance indicators (KPI)."
- "Make every effort to create and maintain equitable workload distribution among CDI staff according to current departmental and organizational conditions and circumstances."
- "Regularly monitor team and individual performance and provide meaningful feedback."

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ACDIS Ethical Principles – General Guidance

- "Use queries as a communication tool to improve the quality of health record documentation, **not to inappropriately increase reimbursement or misrepresent quality of care**."
- "Ensure adequate clinical evidence and/or supportive documentation is noted within the medical record and presented within the associated query."
- "Follow organizational guidelines and/or current industry and clinical practice guidelines to identify clinical criteria for support of queries."

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Compliant Query Practice

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AHIMA/ACDIS: 2019 Guidelines for Achieving a Compliant Query Practice

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Back to the basics…What is a Query?

- A query is a communication tool, used to clarify clinical documentation in the health record for documentation integrity and accurate code assignment in any healthcare setting.
- Queries act as a mechanism to increase precision of clinical documentation which translates into:
  - Accurate clinical picture
  - Accurate patient acuity level
  - Accurate reflection of the providers intent
- The goal is that anyone reading the medical record after discharge comes to the same conclusion

https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942019-update

AHIMA/ACDIS: 2019 Guidelines for Achieving a Compliant Query Practice

- Queries are a method to request additional documentation, so the medical record accurately reflects the clinical condition(s) that were managed during the episode of care, resulting in accurate coding and reporting of patient conditions.
- Are NOT intended to challenge the physician's clinical diagnosis or management of the patient.
  - In clinical validation scenario's it is a lack of documentation that is in question, not the providers judgement

Quality of Documentation *not* Quality of Care

https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942019-update

AHIMA/ACDIS: 2019 Guidelines for Achieving a Compliant Query Practice

All queries, **including verbal queries, should be memorialized to demonstrate compliance with all query requirements to validate the essence of the query** (see below). Regardless of how the query is communicated, it needs to meet all of the following criteria:

- **Be clear and concise**
- **Contain RELEVANT clinical indicators from the health record**
- **Choices must be possible from the clinical indicators provided**
- **Present only the facts identifying why the clarification is required**
- **Be compliant with the practices outlined in this brief**
- **Never include impact on reimbursement or quality measures**

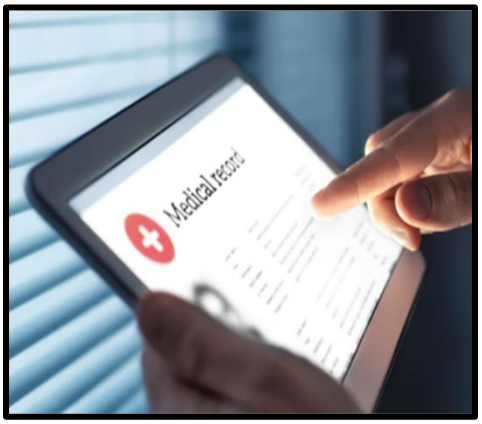
Every CDIS should know the guidelines of query practice briefs.

https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942019-update

AHIMA/ACDIS: 2019 Guidelines for Achieving a Compliant Query Practice

Queries must be accompanied by clinical indicator(s) that:

- Are specific to the patient and episode of care.
- Support the reason that a more complete or accurate diagnosis or procedure is sought.
- Support the reason why a diagnosis requires additional clinical support to be reportable.



https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942019-update

AHIMA/ACDIS: 2019 Guidelines for Achieving a Compliant Query Practice

Query choices should be:

All clinically supported options should be included as well as additional options that permit the provider to craft their own alternate response.

Options may include other, unknown, unable to determine, not clinically significant, integral to, or other similar wording.

https://acdis.org/resources/guidelines-achieving-compliant-query-practice%E2%80%942019-update

AHIMA/ACDIS: 2019 Guidelines for Achieving a Compliant Query Practice

Clinical Validation is NOT an option…

"Statutory Requirements Section 302 of the Tax Relief and Health Care Act of 2006 **requires the Secretary of the Department of Health and Human Services (the Secretary) to utilize Recovery Auditors under the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments under the Medicare program** associated with services for which payment is made under part A or B of title XVIII of the Social Security Act."

According to the Centers for Medicare and Medicaid Services' (CMS) 2011 Recovery Audit Contractor (RAC) Statement of Work, **"Clinical validation is a separate process [from DRG validation], which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented."**

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf

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Office of Inspector General

Healthcare Fraud and Abuse

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Leading Queries and Payer Audits

A leading query can be easily identified by a recovery audit contractor (R.A.C.) auditor.

Auditors identify patterns. Patterns of inappropriate behavior within any institution is a red flag for that facility and they are placed on the radar of the auditor. If patterns continue, the red flag can be escalated up the payer's chain of command. A target, probe and educate (TPE) audit may be initiated. If a facility fails a TPE, the next audit could be an OIG investigation.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE

The Difference Between Healthcare Fraud and Abuse

Medicare Fraud

- **Knowingly submitting, or causing to be submitted, false claims** or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist
- **Knowingly billing for services at a level of complexity higher than services actually provided** or documented in the medical records
- **Knowingly billing for services not furnished, supplies not provided, or both,** including falsifying records to show delivery of such items

Medicare Abuse

- **Abuse describes practices that may directly or indirectly result in unnecessary costs** to the Medicare Program
- **Misusing codes on a claim**, such as upcoding or unbundling codes
- **Upcoding is when a provider assigns an inaccurate billing code** to a medical procedure or treatment to increase reimbursement
- **Can also be a DRG creep** for inpatient admissions

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

Office of Inspector General's Office

What does the Office of Inspector General do?

"The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others.

Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations."

This statutory mission is carried out through a nationwide network of audits, investigations, and inspections.

https://oig.hhs.gov/documents/root/166/COVID-OIG-Strategic-Plan.pdf

OIG Investigations: 3.3 Million Dollars in Overpayments

The OIG determined that the hospital complied with Medicare billing requirements for 80 of the 100 inpatient and outpatient claims they reviewed.

- ***"However, it did not fully comply with Medicare billing requirements for the remaining 20 claims, resulting in overpayments of $201,624 for the audit period."***
- Out of the 20 claims, "13 inpatient claims had billing errors, resulting in **overpayments of $200,495,** and 7 outpatient claims had billing errors, resulting in overpayments of $1,129"
- *On the basis of our sample results, the OIG "**estimated that the hospital received overpayments of at least $1.2 million for the audit period."***
  - *The OIG extrapolates audit findings across the total volume billed for the dates of service audited and then applies the estimated overpayment as the total due. (1.2 million dollars from the 200,495.00 actually audited)*

https://oig.hhs.gov/oas/reports/region4/41808064.pdf

OIG Investigations: 3.3 Million Dollars in Overpayments

The OIG found that the hospital complied with Medicare billing requirements for 51 of the 100 inpatient and outpatient claims they reviewed.

- ***"However, the hospital did not fully comply with Medicare billing requirements for the remaining 49 claims, all of which were inpatient, resulting in overpayments of $590,646 for CY's 2016 and 2017"***
- **On the basis of our sample results, the OIG estimated that the hospital received overpayments of at least $3.3 million for CYs 2016 and 2017**
  - *Again, when extrapolating audit findings from the sample cases included within the audit, the errors identified are then applied across the volume of claims billed in the two-year time span, for which **the total due is 3.3 million.** Another words, they take a sample of whole and apply the identified errors across the whole for the total amount due.*

https://oig.hhs.gov/oas/reports/region4/41808064.pdf

Charges Filed Under the False Claims Act – Public Record

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

United States Court of Appeals
Fifth Circuit
FILED
May 28, 2020
Clerk

No. 19-50818

UNITED STATES OF AMERICA, ex rel., INTEGRA MED ANALYTICS, L.L.C.,

Plaintiff–Appellant,

v.

BAYLOR SCOTT & WHITE HEALTH; BAYLOR UNIVERSITY MEDICAL CENTER–DALLAS; HILLCREST BAPTIST MEDICAL CENTER; SCOTT & WHITE HOSPITAL–ROUND ROCK; SCOTT & WHITE MEMORIAL HOSPITAL TEMPLE,

A Qui Tam case is one in which an individual or corporation files a lawsuit against a facility or provider with ***claims of violation of the False Claims Act,*** on behalf of the United States Government.

Let's take a closer look at what the charges were so you can see how they could impact you or your facility.

https://casetext.com/case/united-states-ex-rel-integra-med-analytics-llc-v-baylor-scott-white-health

Charges Filed Under the False Claims Act – Public Record

- According to the filing of this case, “Integra Med Analytics, L.L.C., filed a qui tam suit on behalf of the United States against Baylor Scott & White Health system and its affiliates under ***the False Claims Act for allegedly using inflated codes to bill Medicare.”***
- The brief continues to state: “The Baylor Scott & White Health system and its affiliates (Baylor) operate a network consisting of around ***twenty inpatient short-term acute care hospitals in Texas***. A significant number of patients served by Baylor are covered by Medicare. Thus, Baylor regularly submits reimbursement claims to Medicare”
- “In this case, Integra Med Analytics, L.L.C. (Integra Med) alleges that Baylor submitted **$61.8 million in fraudulent claims** to Medicare, in violation of the False Claims Act (FCA)”

Case: 19-50818 Document: 00515431386 Date Filed: 05/28/2020

Integra Med Alleged the Following:

- Baylor trained its physicians and CDI employees to "up-code“ by promoting MCC’s and also provided a list of high value MCC’s to providers
- Trained its physicians to focus on key words and emphasized that using certain terms would increase their performance pay
- Baylor had its CDI employees seek opportunities to use higher value secondary codes
- Baylor pressured physicians to alter their original diagnoses by providing documents and asking them to "specify“ or change their diagnosis if the diagnosis did not include CCs or MCCs

https://law.justia.com/cases/federal/appellate-courts/ca5/19-50818/19-50818-2020-05-28.html

Integra Med Alleged the Following:

- Clarification documents requested physicians to "specify" their diagnoses and would often suggest either specific revenue-increasing CCs or MCCs or provide options listing several possible CCs and MCCs
- Integra Med alleges that Baylor provided unnecessary treatment in order to code high-value MCCs (named were Encephalopathy, Acute Respiratory Failure and Malnutrition)
- They claimed that use of ventilator hours were substantially higher than the national average after the same procedure (> 96 hrs. on mechanical ventilation)
- "Integra Med also relied on several statements from a former Baylor medical coder in concluding that Baylor had defrauded Medicare. According to Integra Med, this medical coder recalled a then-Baylor executive "telling CDIs things that were totally not true" as a part of a deliberate effort to promote the coding of MCCs."

https://law.justia.com/cases/federal/appellate-courts/ca5/19-50818/19-50818-2020-05-28.html

The Conclusion: False Claims Act – Dismissed

The ***district court granted Baylor's motion to dismiss***, holding that Integra Med's complaint ***failed to state a particularized claim for which relief could be granted as required*** by Federal Rules of Civil Procedure 8(a) and 9(b).

- The conclusion that Baylor was simply ahead of the healthcare industry in following CMS guidelines is supported by the data in Integra Med's own complaint
- Baylor's use of tip sheets is consistent with the fact that coding and clinic terminology are often different

Ethical Practices in CDI DO Matter

https://law.justia.com/cases/federal/appellate-courts/ca5/19-50818/19-50818-2020-05-28.html