Ethics in Coding

I. INTRODUCTION

AAOMS has developed a series of coding papers designed to provide specific information on coding claims for oral and maxillofacial surgery (OMS).

II. ETHICS

Oral and maxillofacial surgeons have a clear responsibility to provide high quality specialty care for their patients. In an ideal world, treatment decisions are made after all likely diagnoses, treatment alternatives and risks are explained, the informed patient accepts the plan most likely to succeed in the management of their condition, according to their personal goals and family obligations, and reflecting confidence in the surgeon's judgment based on his or her knowledge and experience as a skilled surgeon. Physical, emotional and intellectual interaction with a surgeon would help to generate this trust. The informed patient would be cooperative, accepting of known complications and satisfied with the treatment regardless of the outcome, according to its specific goals. The surgeon should be gratified emotionally as well as reasonably compensated financially.

Some factors that might create a less ideal patient-physician relationship? A surgeon who is too busy, autocratic, uncommunicative or unskilled. A patient who is combative or untrusting, cannot understand or cannot make decisions, is inordinately fearful, is spontaneously litigious, or is handicapped financially. Another factor can be introduced by third parties.

Third parties include the patient's family, other care providers, including clinical and hospital staff and administrators, attorneys (rarely), and with increasing frequency, third-party payers. Most of the time, experienced, humanistic surgeons have the skill to manage the concerns (and sometimes irrational intrusions) of family members, to elicit appropriate behaviors in their medical system colleagues at every level, to contribute to quality assurance improvements in the institutions in which they operate, and to achieve outcomes that substantially reduce the probability of collisions with attorneys. But what about third-party payers?

The *Saturday Evening Post* covers by Norman Rockwell portrayed an age when the family doctor provided the best care he could and the patient paid what they could. Nothing else was expected. Since that time (if it ever truly existed), the cost of dental and medical education has steadily climbed and doctors' time in training and education debts are higher than ever before. The miracles of modern medicine have offered cures and treatments only dreamed of in former times, but at the cost of huge increases in hospital fees and proportional elevations in alternative site costs. When Rockwell was painting, FDR was governing. Americans were lifted out of a depression, Social Security was created, and Americans came to expect insurance against loss of income and assurance that health care was accessible. Health insurance grew into a major industry. But the industry's original operational structure could not keep up with mounting health care costs. Managed care was the solution. Managed care is the third-party that now challenges our ability to provide the care that our patients deserve.

Certainly, we have all encountered patients who could afford the treatment they need, but who cannot accept paying more than their insurance provider will authorize. We also know many patients who don't have that option. All of us, doctors and patients alike, do not invest enough effort in reading the fine print in our contracts; the pre-existing condition clauses; the exclusions; the fine print. The patient's union negotiates health benefits with the patient's company, or the business owner determines what the company can afford. Take home pay wins out over additional medical policy benefits. The details are not considered until the reality of illness intervenes. Insured patients expect payer intervention in almost every case and are often willing to acquiesce to the financial considerations brought to bear by the third party payer. The surgeon is first and foremost obligated to the patient to make the best treatment recommendations, although it may sometimes

be necessary to modify the ideal course of treatment. This may be acceptable if the patient has been made aware of all risks, benefits and other options. Should compromise be unacceptable and educational efforts with the payers fail, an ethical dilemma may arise.

The coding systems used to report diagnoses and procedures to third parties unavoidably contain elements of subjectivity and imprecision. Manipulation of codes in an effort to deceive the payer may be rationalized by some based on quality patient care. Justification may be predicated on "helping the patient receive the highest quality care." However righteous the cause may seem, it is illegal and unprofessional conduct to falsify insurance claims and it is deemed unethical under the AAOMS "Code on Professional Conduct." The Code addresses this issue in Chapter V, Section H, Honesty and Truthfulness and specifically in Advisory Opinion H.2.00 under the heading "Billing Responsibilities." The billing codes that should be selected by the surgeon represent a report which approximates the amount of effort and time invested in assessing the patient's history, examining their person and their medical data, determining a diagnosis, formulating a treatment plan, explaining and coordinating care, delivering surgical or treatment services, following up to ensure recovery, and the costs of operating the surgeon's practice and paying for medical insurance. A surgeon would not delegate the dictation of his or her findings of an evaluation, the dictation of the surgical operation, or the narrative of the hospital stay. The surgeon should not delegate the choice of the billing codes for those services either.

It is therefore incumbent upon every surgeon to be knowledgeable in the use of those codes that summarize the surgeon's relationship with the patient and the coding systems utilized by his/her practice. This includes appropriate training not only for staff assigned coding responsibility, but also for the Captain of the Ship. When unsure, both doctors and coders should seek clarification from a knowledgeable source such as AAOMS, which provides support and training through coding classes offered on a regular basis. Coding ethics must be based on the fundamental moral principle that governs our behavior and obligations toward one another: the duty to be truthful in our communications. Our commitment to quality patient care must continue even as we find ourselves in the midst of an evolving health care system constrained by budgetary concerns.

III. LEGAL IMPLICATIONS

Despite accreditation requirements that residents be taught coding, the thrust of resident education remains learning and delivering the medical and surgical services essential to provide quality care, earn a living, and repay debt. The same doctors who work valiantly to care for their patients and stay abreast of medical literature often do not seek education in how to select the codes that correctly represent the patient care provided.

There is great risk in this behavior. Medicare has created strict guidelines for correct coding and billing. Medicare compliance rules are commonly adopted by all other managed care organizations. These rules are constantly evolving and reported in the Federal Register, Medicare publications, and medical industry communications at a dizzying pace.

Ignorance of the law is no excuse and penalties, including imprisonment, are severe. Compliance rules and related fines and penalties, as well as the ethical commitment to our patients, will continue to place additional pressure on the OMS "to do it right." The evolving universal electronic medical record and mandated electronic submission of all claims will facilitate statistical analysis of every doctor's practice and every practice's claims history. Many analyses are possible even now. The experience of each surgeon, incidence of disease and disorders in their patients, and treatments provided will be more easily compared in the future. Surgeons whose coding statistics fall outside reasonable parameters will need to defend their procedures and records.

Routine forgiveness or waiver of insurance co-payments may not only violate the provider agreement that the doctor has with the insurance carrier; they may constitute fraud under state and federal statute.

The AAOMS Committee on Health Care and Advocacy (CHCA) has a full time staff of dedicated, knowledgeable personnel who read and interpret all of the pertinent rules and regulations and who review their findings with volunteer AAOMS members – active surgeons confronted by the same struggle to do the right thing and to honestly report their patient encounters. CHCA encourages all AAOMS

doctors to ensure their own education and the veracity of their reporting and billing practices by attending AAOMS Coding Courses and referring any questions on coding and nomenclature issues to CHCA.

Coding Paper

Note: This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided to you in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by you or anyone else in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisers.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery (OMS). This paper discusses ethics in coding.

Proper coding provides a uniform language to describe medical, surgical, and dental services. Diagnostic and procedure codes are continually updated or revised. The AAOMS Committee on Health Care and Advocacy has developed coding guidelines to assist the membership to use the coding systems effectively and efficiently.

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