Have You Heard the Latest Professional Liability Risk?

HIPAA allows states to recognize cause of action for breach of confidentiality

The list of liability risks for physicians continues to increase. On behalf of the Medical Liability Committee, this article presents new risks via highlights from a recent discussion with Jeannine M. Foran, BSN, JD, a Connecticut healthcare attorney who leads the Health Care Practice Advisory Group at Heidell, Pittoni, Murphy & Bach, LLP, in Bridgeport, Conn.

Dr. Marks: What is the latest liability risk that physicians should be concerned about?

Ms. Foran: Liability risks are generally local; however, when a risk is identified in one state, it may not be long before it occurs in other states. The Connecticut Supreme Court, forsaking long-standing precedent, now joins many other states in recognizing a cause of action for breach of
confidentiality. In Byrne v. Avery Center for Obstetrics and Gynecology, PC, the Supreme Court held that physicians may be sued for negligence and negligent infliction of emotional distress caused by unauthorized disclosures of medical information.

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Are Physicians Required to Return Overpayments?

Are Physicians Required to Return Overpayments?
AAOS Now- May 2018
By: Michael R. Marks, MD, MBA, and Michael Sacopulos, JD

When overpaid, many providers wonder if they need to return the funds. The short answer is yes. An overpayment is money that does not belong to providers and keeping it exposes them to collection and other risks.

The U.S. Centers for Medicare & Medicaid Services (CMS) ruled that Medicare overpayments must be refunded within 60 days. However, some practices are passive on the issue and many do not have a policy addressing these funds. For example, during a recent discussion with a client, it was discovered the practice had not run the Medicare Credit Balance Report in nearly a year. When they did, they were astounded to learn they owed more than $300,000.

If your practice hasn’t run this report, immediately do so. Consult your practice’s attorney for assistance on how to address any overpayments. Medicare’s rules are specific. To review their fact sheet, visit https://go.cms.gov/1Oy2sK1.
Medicare overpayments can occur for a variety of reasons, such as insufficient documentation, medical necessity errors, duplicate payments, and administrative and processing errors. The look-back period is six years. When your office identifies an overpayment within that period, you must report and return the overpayment within either 60 days after identifying the overpayment or by the due date on any corresponding cost report, whichever is later.

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Michael R. Marks, MD, MBA

Michael Sacopulos, JD
An accurate understanding of coding rules increases likelihood of receiving appropriate payment. Correctly reporting and billing for arthroscopy services is often confusing.

Last month, AAOS Now reviewed the knee arthroscopy codes and outlined the appropriate use of modifiers. This month, the topic is coding for shoulder and hip arthroscopic procedures.

**Arthroscopic shoulder procedures**
The traditional coding rule about the shoulder is to consider the joint as one compartment. Due to continuous efforts by orthopaedic societies, a two-compartment (intra- and extra-articular) viewpoint is gaining acceptance. As a result, a few coding rules have changed. Intra-articular structures include the labrum, the long head of the biceps, a Bankart lesion, and the humeral and glenoid articular surfaces. Extra-articular structures include the rotator cuff (RC), the distal clavicle,
and the subacromial space.

In 2017, the Centers for Medicare & Medicaid Services (CMS) made a significant change to the extensive débridement code (29823). There are now three situations in which this code can be billed if the extensive débridement portion of the procedure is performed in a separate area of the shoulder joint. This is similar to coding for the knee, which also has distinct anatomic compartments. The applicable codes are:

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Arthroscopy Coding for Major Joints – Knee

Michael R. Marks, MD, MBA

When the American Medical Association (AMA) published the first edition of Current Procedural Terminology (CPT) to standardize surgical procedure terminology and reporting,
modern arthroscopy was in its infancy and no CPT code described it. As the number of arthroscopies for knee, shoulder, and hip conditions has exploded during the past few decades, CPT has attempted to address the reporting needs of these procedures. However, the constant clinical and technological advances, and the fact that CPT is only updated annually, have resulted in codes that lag behind common techniques. This scenario, in turn, has generated a good deal of confusion among surgeons and coders about how to correctly report and bill for these services.

The next CPT code changes to arthroscopic codes are scheduled for January 2019. To ensure correct coding until then, AAOS Now will present essentials for coding the most common arthroscopy codes. This month focuses on the knee; subsequent issues will feature shoulder and hip codes.

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Have You Heard the Latest Medical Liability Risk?

Michael R. Marks, MD, MBA
Have You Heard the Latest Medical Liability Risk?
AAOS Now – January 2018
By: Michael R. Marks, MD, MBA and Daniel R. Schlatterer, DO, MS

Court rules that surgeons must personally deliver informed consent
On June 20, 2017, the Commonwealth of Pennsylvania Supreme Court handed down a 4–3 decision that has the potential to rock the world of medical liability. The justices ruled that surgeons, in order to obtain informed consent, have the duty to provide their patients with information about the risks, benefits, and alternatives of a particular procedure. Furthermore, surgeons must deliver that information personally.

Who is responsible?
In the underlying case, the patient filed a lawsuit alleging that all risks of a procedure were not fully discussed, which lead to discovery of the consent process. The Pennsylvania MCARE (Medical Care Availability and Reduction of Error) Act requires that physicians obtain informed consent and that certain information must be conveyed to patients to inform their consent. Utilizing Pennsylvania common law, a majority of the justices declared that the duty to obtain informed consent rests with the physician performing a procedure and not the hospital where it will be performed.

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What orthopaedic surgeons need to know

Last month, I coauthored an article on Health Insurance Portability and Accountability Act (HIPAA) compliance that offered tips on how orthopaedic practices can keep their patients’ information safe (see “Top 10 HIPAA Mistakes to Avoid, AAOS Now, September 2017”). In this article, I speak with Les Trachtman, CEO of Purview, a patient-driven healthcare technology company, about medical imaging and HIPAA compliance.

Dr. Marks: Do orthopaedic surgeons need to be concerned about medical imaging and potential HIPAA implications?

Mr. Trachtman: Although medical imaging may not be the primary focus of HIPAA or the Health Information Technology for Economic and Clinical Health Act (HITECH), medical images are considered protected health information (PHI). Often much larger than their medical record counterparts, medical images are typically dense data files that may exceed a gigabyte in
size. Because storage, sharing, and archiving of medical images pose unique challenges for practitioners, it is important to understand how to best manage this information without running afoul of regulations.

Top 10 HIPAA Mistakes for Practices to Avoid

The Health Insurance Portability and Accountability (HIPAA) Act of 1996 continues to challenge every medical practitioner. A recent discussion on the current state of HIPAA revealed the top 10 mistakes that practices make during implementation.

This year has been rough in terms of privacy. The Office of Civil Rights (OCR) has consistently levied stiff financial penalties on those who violate HIPAA rules. Hacking and ransomware attacks are more frequently in the news. If the confidentiality of patient medical records is not to become a quaint idea of a bygone age, practices need to be proactive. The following mistakes can be avoided, putting your practice on the way to patient privacy protection and HIPAA compliance.

No. 10: Failure to have Business Associate Agreements in place
A Business Associate is a person or entity to whom you provide patient information. These may include third-party billing companies and the service that shreds old documents. Most practices have many Business Associates. The OCR has a free online Business Associate Agreement template that can easily
Is Your Practice Not Getting Paid?

AAOSNow – July 2017
by Michael R. Marks, MD, MBA, and Cheryl Toth, MBA

Coding May Not Be the Reason
It’s easy to blame a practice’s skyrocketing accounts receivable (A/R) on coding and the insurance companies. But our experience with orthopaedic practices, and the results of AAOS/KarenZupko & Associates (KZA) pre-workshop surveys on coding and reimbursement, indicate that the problem is a lot more complex.

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Michael R. Marks, MD, MBA

Cheryl Toth, MBA
Every autumn, the American Medical Association’s (AMA) Current Procedural Terminology (CPT) book is updated with changes for the next year. In 2016, minimal changes were made, possibly due to the implementation of the International Classification of Diseases, 10th edition (ICD-10) and a desire to not overload physician practices. In a prior article, 2017 changes for the spine area were presented. (See “2017 Spine CPT Code Changes,” AAOS Now, November 2016.) This column points out the CPT changes made for the foot and toes region.

In summary, effective Jan. 1, 2017, two new codes—28291 and 28295—have been established to report bunionectomy procedures, three codes—28290, 28293, and 28294—have been deleted, and six codes—28289, 28292, 28296, 28297, 28298, and 28299—have been revised.
7 Golden Rules for Reducing Hip Arthroscopy Denials

Michael R. Marks MD, MBA

AAOS Now – December 2016
by Michael R. Marks, MD, MBA

If a constant stream of denials for hip arthroscopy procedures frustrates you, know that you are not alone. These denials are a common source of angst for physicians. The good news is, if you know how to avoid common coding pitfalls, document correctly, and follow payer medical policies, most of these denials will disappear.

The key is having proper documentation, prior to submitting the claim.

Hip Arthroscopy from a Coding Context
This minimally invasive hip surgery is still relatively new. Although the number of Current Procedural Terminology (CPT) codes is expanding, carrier policies have not quite caught up with the orthopaedic community’s acceptance.