Skin biopsy codes are changing.

**EDITOR’S NOTE:** This is the second installment in a two-part series on the 2019 CPT® codes released recently by the American Medical Association.

For many years we have used two codes to report skin biopsies. CPT 11100 for the first lesion and 11101 for each additional lesion biopsied after the first lesion on the same date of service. These codes included all methods of removal.

The new code ranges are CPT 11102-11107 and are reported based on method of removal which allows for greater specificity. New guidelines were created to help with coding and reporting of these codes. The new CPT codes are as follows:
New code changes number 335.

The new current procedural terminology (CPT®) codes have been released with 335 code changes in 2019. There were many code revisions with guideline, description and instructional note changes. Let’s look at the highlights of many new CPT codes for 2019.

There six new codes in the Evaluation and Management (E&M) section in CPT. Guidelines were revised for Interprofessional
Telephone/Internet/Electronic Health Record Consultations. New codes 99451 and 99152 were added to report assessment and management services. The codes are based on medical consultative time.

New CPT codes 99453 and 99454 were added to report remote physiologic monitoring services during a 30-day period. Other codes in this section (99446-99449 and 99091) were revised.

These new codes reflect the key role non-verbal communication technology plays in care coordination between consulting and treating physicians, according to the AMA.

CPT code 99457 is a new code that requires live, interactive communication with the patient/caregiver and 20 minutes or more of clinical staff/physician or other qualified health care professional time in a calendar month.

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Reasons Why Diagnostic Coding Matters in Value-based Care

Margaret Maley, BSN, MS
Payers are great at collecting data. They use the information to develop payment policies, determine reimbursement rates, and, increasingly, to negotiate value-based contracts. Payers profit because they know how much it costs to take care of patients with certain illnesses and comorbidities. Payers know how to harness the power of data.

Orthopaedic surgeons—not so much.

Most orthopaedists fail to document and assign even the most basic data, such as comorbid conditions, that would support a higher cost of care in terms of time, visits, and complications. If you treat a highly complex patient base and aren’t diligently documenting such data, you will not fare well in a value-based payment world. As the Centers for Medicare & Medicaid Services (CMS) and commercial payers shift risk to providers in the form of bundled and value-based contracts, the importance of reporting diagnostic data has become paramount. The following are seven reasons why.

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Refresh your Referral Building
Years ago, a “good referral” was described using the Three A’s of medicine: Availability, Affability, and Ability. A physician striving to build a successful practice was advised to deliver all three.

Managed care contracts and narrow networks temporarily stifled traditional referral building. But the patient rebellion against limited choices pushed the pendulum back to center, and today, high-deductible health plans and out-of-network options have patients once again voting with their feet. Refreshing your referral building activity has never been more important to patient volume or practice revenue.

Here are five ways a modern practice can use the Three A’s in its referral building.

1. Capture and track referral data accurately.

This is the baseline of any effective referral building strategy, but it is very often skipped. Here’s how to make sure the data is accurate and meaningful:
Have You Heard the Latest Professional Liability Risk?

AAOS Now - June 2018
By: Michael R. Marks, MD, MBA

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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Tips for Utilizing ICD-10-CM

Sarah Wiskerchen, MBA, CPC

Tips for Utilizing ICD-10-CM – June 2018
AAOSNow
by Sarah Wiskerchen, MBA, CPC

In May 2015, most orthopaedic surgeons and their staff were highly focused on learning the new diagnostic language of ICD-10-CM (International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification). That’s because the new diagnosis codes were scheduled to replace ICD-9-CM in October 2015. Three years later, practices are still learning how to utilize the ICD-10-CM code set to support the services they perform. This article outlines five important tips to aid physicians and coders in
selecting the appropriate ICD-10-CM codes.

No. 1: Injury codes

Do use chapter 19 injury codes when the documentation states that an injury occurred. Don’t assign pain diagnoses to every orthopaedic claim.

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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
Coding Trigger Point Injections for Pain Management

ICD10 Monitor – April 2018
by Deborah Grider, CPC, COC, CPC-I, CPC-P, CPMA, CEMC, CCS-P, CDIP

Review your payer policies when performing these services.

Pain management coding can be tricky. Trigger point injection therapy is a common procedure performed by pain management specialists, orthopedic surgeons, physical medicine and rehab and other specialties. Trigger point injection therapy is used for the treatment of myofascial pain syndrome (MPS).

According to the American Society of Regional Anesthesia and Pain Medicine. Myofascial pain is a common, non-articular musculoskeletal disorder characterized by symptomatic myofascial trigger points – hard, palpable, localized nodules within taut bands of skeletal muscle that are painful upon
compression. MPS is a chronic condition affecting the connective tissue (i.e., fascia) surrounding the muscles; sensitive points in your muscles (trigger points) cause referred pain in seemingly unrelated parts of the body. MPS typically occurs after a muscle has been contracted repetitively. The large upper back muscles are prone to developing myofascial pain, as well as the neck, shoulders, heel and temporomandibular joint.

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Arthroscopy Coding for Major Joint – Shoulder

Michael R. Marks, MD, MBA

Arthroscopy Coding for Major Joints – Shoulder

AAOS Now – March 2018

By: Michael R. Marks, MD, MBA

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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**Telehealth: A New Frontier for Care Delivery**
One only needs to look at recent weather-related tragedies to see the impact of telehealth. Victims of hurricanes Harvey and Irma who had no way of getting to a clinic or hospital were able to be seen by physicians remotely. Telehealth providers such as Doctor on Demand, LiveHealth Online, EpicMD, and Nemours offered telehealth visits at no charge to the patients affected by the hurricanes in Texas and Florida. Florida Hospital offered free telehealth care, and nearly 3000 people took advantage of the services in a three-day period.’ The use of telehealth allowed for patients affected by natural disasters to be able to get medical care that they might have otherwise not been able to receive. This article discusses the basics of telehealth, how it is being used in practices, and the coding, billing, and reimbursement issues related to getting paid to deliver it.


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