Answers to Five Common Coding Questions

What orthopaedic surgeons, practice managers, and staff want to know

In this article, we discuss five concerns from surgeons and their staff that are currently “trending.”

1. Vendor advice = a flashing yellow light

**Question:** Our orthopaedic surgeon recently performed a single-level anterior cervical diskectomy and fusion and reported
Current Procedural Terminology (CPT) codes 22853 and 22845 for the intervertebral biomechanical device and anterior instrumentation. When I look up the device name, it includes the description “low profile,” and I don’t see documentation for, or the name of, a separate plate in the operative note. The physician told me the vendor said it is okay to report both codes. Is this correct?

**Answer:** When reporting plate instrumentation in conjunction with insertion of intervertebral biomechanical devices, specific criteria must be met to support reporting an additional code. The CPT description of 22853 includes the phrase, “with integral anterior instrumentation for device anchoring (e.g., screws, flanges).”

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**Don’t Be the Next Victim of Billing Fraud and Abuse**

Michael R. Marks, MD, MBA

Don’t Be the Next Victim of Billing Fraud and Abuse
AAOS Now- October 2018
By: Michael R. Marks, MD, MBA
Every physician has scenarios they seek to avoid: bad nights on call, less than optimal outcomes, and the fear of malpractice suits. What many don’t think about are coding mistakes that could result in federal investigators knocking on the office door. Audits may uncover coding errors, resulting in stiff fines and even jail time.

Examples of Medicare fraud include:

- knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a federal healthcare payment for which no entitlement would otherwise exist
- knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by federal healthcare programs
- making prohibited referrals for certain designated health services
- Examples of Medicare abuse include:

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2019 CPT® Coding for Skin Biopsies

Deborah
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:

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AMA Releases 2019 CPT® Code Set
AMA Releases 2019 CPT® Code Set
ICD10 Monitor – September 2018
by Deborah Grider, CPC, COC, CPC-I, CPC-P, CPMA, CEMC, CCS-P, CDIP

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

Reasons Why Diagnostic Coding Matters in Value-based Care
AAOS Now – September 2018
by Margaret M. 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

Karen Zupko, President

Physicians Practice – August 22, 2018
by Karen Zupko

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:

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Have You Heard the Latest Professional Liability Risk?

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

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?

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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Coding Trigger Point Injections for Pain Management
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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