Answers to Five Common Coding Questions

Margaret Maley, BSN, MS

Sarah Wiskerchen, MBA, CPC

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AAOS Now – October 2018
by Margaret M. Maley, BSN, MS and Sarah Wiskerchen

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).”

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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Reasons Why Diagnostic Coding Matters in Value-based Care

Margaret Maley, BSN,
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.
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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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
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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Arthroscopy Coding for Major Joints – Knee

Michael R. Marks, MD, MBA

Arthroscopy Coding for Major Joints – Knee

AAOS Now – February 2018
By: 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
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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