Risks Associated with Critical Care Coding

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

Questions abound when reporting critical care services.

Reporting Adult Critical care can be complicated. It is not only the coding but the rules and that go along with critical care. Many questions come up when reporting critical care services. You would think it would be fairly straightforward since there are only two codes for adult critical care, 99291 for the first 30-74 minutes and 99292 for each additional 30 minutes in a calendar date. But questions always arise when a practitioner is performing critical care.

Supporting Medical Necessity for Critical Care

According to CPT® 2017: “Critical care is the direct delivery by a physician(s) or other qualified health care professional
of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.”

According to CMS and other payers, critical care must be medically necessary and is a service as service that encompass both treatment of “vital organ failure” and “prevention of further life-threatening deterioration of the patient’s condition”.

Read Full Article

Arthroscopy Coding for Major Joints – Knee

Michael R. Marks, MD, MBA

Arthroscopy Coding for Major Joints – Knee
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.

Read Full Article

What is in that alphabet soup? Deciphering coding acronyms to support
What is in that alphabet soup? Deciphering Coding Acronyms to Support Reimbursement
Healio Orthopedics • Orthopedics Today – January 2018
by Sarah Wiskerchen, MBA, CPC

The physician’s role in the revenue cycle is important for optimizing charge capture in independent and employment settings. Understanding key acronyms related to code sets and reimbursement guidelines is important to an organization’s bottom line and future physician compensation.

This article explains five coding acronyms that physicians must understand, how they differ and why each is important.


CPT is a code set used in health care billing to describe both professional and diagnostic services. CPT codes are typically the foundation of insurance company reimbursement for physician services, and both private practices and hospitals are reimbursed at either government-assigned allowable rates or payer-contracted rates. Thus, correct CPT reporting is essential for revenue optimization. The frequency of CPT reporting may impact physician compensation, as many employed physicians are credited for work relative value units (RVUs)
Have You Heard the Latest Medical Liability Risk?

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.

Read Full Article

Dispensing DME in Orthopaedics for Medicare

Sarah Wiskerchen, MBA, CPC

Dispensing DME in Orthopaedics for Medicare – November 2017
AAOSNow
by Sarah Wiskerchen, MBA, CPC

Answers to key coding questions
Orthopaedic practices often provide patients with supplies, such as casts and canes, integral to patients’ treatment plans.

This article covers the essentials of coding and claims submission. Understanding the definitions and rules for DME can help practices make more effective decisions on which supplies to offer patients as well as help them ensure that items are both accurately reported and appropriately paid.

The article also focuses on Medicare policy, which applies nationally.

Q. What exactly is DME?

DME—or durable medical equipment—is often used to refer to a range of supplies and assistive devices that are dispensed in a healthcare setting. However, not all of these items are classified as DME within the coding system used for billing.

According to the Centers for Medicare & Medicaid Services (CMS), DME is “medically necessary durable medical equipment, prosthetics, orthotics, and disposable medical supplies (DMEPOS), which includes oxygen and related supplies, parenteral and enteral nutrition, and medical foods.” DME is primarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient’s home. In some cases, DME items are rented, but in orthopaedics they are usually purchased.

Q. What supply items might be used in an orthopaedic office? How does a coder know which codes to use?

Read Full Article
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.

Read Full Article

Six Steps for Conducting an Internal Evaluation & Management Audit

Sarah Wiskerchen, MBA, CPC

Six Steps for Conducting an Internal Evaluation & Management Audit

Healio Orthopedics • Orthopedics Today – September 2017
by Sarah Wiskerchen, MBA, CPC

Evaluation and management coding patterns are under the microscope. CMS is monitoring evaluation and management code usage by specialty, state and nationally. The Recovery Audit Program of CMS aims to identify and correct improper Medicare payments through the detection and collection of overpayments.
Commercial payers are using analytics to identify potentially inaccurate coding, too; take-backs may result.

An annual review of each provider’s evaluation and management (E/M) code usage is essential to effectively manage the audit risk of your practice. The process of reviewing documentation identifies coding pattern or usage anomalies — possible non-compliance. This, in turn, uncovers opportunities for educating physicians and staff on how to properly document, code and bill for services according to federal, state and payer guidelines.

Read Full Article

Work RVU compensation formulas and surgery modifiers: To discount RVUs or not

Sarah Wiskerchen, MBA, CPC

Work RVU compensation formulas and surgery modifiers: To discount RVUs or not
In hospital employment settings, as well as large groups, work relative value unit-based compensation agreements and formulas are often standard. Understanding how work relative value units are credited is an essential element of creating or negotiating relative value unit-based compensation. Our firm has found there is no single method applied within physician organizations that use relative value unit-based compensation. This article explains why some work relative value unit reductions make sense and others should be carefully addressed with administrators.

Since 1992, many physician organizations have used work relative value units (RVUs) as a methodology for physician productivity and as an element of their physician compensation formulas. Work RVUs are published annually as part of the Resource-Based Relative Value Scale (RBRVS) developed by the CMS.

Read Full Article

Is Telemedicine the Future of Healthcare?

Deborah
Is Telemedicine the Future of Healthcare? Understanding the Reporting Requirements for Telemedicine Services – September 2017
by Deborah Grider, CPC, COC, CPC-I, CPC-P, CPMA, CEMC, CCS-P, CDIP

EDITOR’S NOTE: National Quality Forum (NQF) issued two new reports this week that provide guidance to advance health information technology, with the intent of making healthcare more effective and safer for all Americans.

The terms “telemedicine” and “telehealth” have been used interchangeably in healthcare, but there is a difference. Telemedicine is considered the clinical application of technology, while telehealth encompasses a broader, consumer-facing approach – “a collection of means or methods, not a specific clinical service, to enhance care delivery and education,” according to the federal network of telehealth resource centers.

Telehealth is not a new concept. In 1925, Hugo Gernsback developed a concept for a teledactyl, a tool that used robot-like fingers along with radio technology to examine a patient from a distance via a video feed. Unfortunately, this tool was never actually produced, but rather predicted as a future path for medicine.

According to the American Telemedicine Association (ATA), telehealth has four primary benefits:

1. Improves patient access
2. Reduces cost
What’s a service orthopaedic practices can offer that is popular with patients, reimbursed by most payers, not too expensive to implement, and deliverable in all 50 states? Telehealth: Although it’s obviously not suitable for every type of patient encounter, the value telehealth confers to patients, practices, and payers has pushed adoption to the tipping point. These services also allow practices to differentiate themselves.

**Why consider telehealth?**

According to the American Telemedicine Association (ATA), telehealth has four primary benefits, as follows:

1. Improved access
2. Reduced costs
3. Improved quality/safety
4. Improved patient satisfaction

Indeed, a 2015 Harris Poll found that 64 percent of patients were willing to participate in telehealth visits because of convenience. The ATA says more than 15 million Americans received at least some medical care remotely in 2015, and it expects those numbers to grow by 30 percent in 2017.