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THE CODE

The Official Medical Coding Newsletter of MiraMed, A Global Services Company

Adopting a Total Quality Management Approach to Medical Coding

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The "gold standard" process improvement methodologies known as Lean and Six Sigma (LSS) are finding a multitude of applications in many aspects of healthcare. Often used together, these data- and metrics-driven processes offer opportunities to develop simple ways to complete complex tasks and achieve continuous improvement. MiraMed has begun adapting these tried-and-true methodologies in the complex area of medical coding, and has incorporated LSS into a larger total quality management (TQM) approach to this difficult but essential function.

Healthcare organizations are continuously challenged to ensure that clinical information is correctly translated into a specific set of diagnosis and procedure codes. Traditionally, the accuracy score for an individual coding professional or an organization has been defined as the number of correctly assigned codes over the number of potential correct codes. Most organizations set a baseline goal for an "accuracy score" in the 90th percentile.

A large number of medical coders can and do achieve accuracy scores in the 80th, 90th and even 100th percentiles. However, these high accuracy scores do not always reflect all aspects of the overall quality of the coding. Many organizations still have a high number of coding errors even when their coding professionals achieve high accuracy scores. In short, *high coding accuracy does not necessarily mean high coding quality*. A coder with an accuracy score of 96 percent, for example, could be persistently coding from incorrect sections of the chart.

CPT code 76140 (Consultation on x-ray examination made elsewhere, written report) is intended to be

Some other common sources of persistent coding errors include:

- A long time lapse between coding and the review and scoring of medical charts. Some coding providers measure accuracy only quarterly or annually.

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- Remedial training assigned to coders that does not align with the types of errors the coders are actually making.
- A piecemeal approach to evaluation and training.

MiraMed's TQM approach to coding incorporates LSS and other types of specific data elements to evaluate the coding and auditor base with a real-time view of performance that includes additional aspects of coding beyond accuracy. MiraMed uses that data to drive ongoing coding quality improvement. At the same time, MiraMed closely follows industry trends, and works with clients on their specific areas of focus and need.

MiraMed's TQM methodology consists of three layers of governance: Voice of the Customer (a fundamental principle of LSS that grounds improvements in client needs), Enterprise Management and Tactical Management. These three layers work together across the business to deliver coding that is not only more accurate but that also yields qualitatively and holistically better coding. MiraMed has also looked through the client lens and extended its efforts beyond traditional remedial training for coders to strive to deliver coding quality and information that will ultimately have a genuine impact on clients' business.

The cornerstone of MiraMed's TQM approach is the Quality Leadership Team—a designated group of individuals credentialed and highly skilled in medical coding and/or health information management. The team makes accuracy- and quality-related observations and recommendations for clients at least weekly, based on real-time data. The team's recommendations are implemented within 48 hours using historical data and data that is as recent as the same day.

MiraMed's Quality Leadership Team has used this approach to review and improve multiple areas of coding for clients. To optimize coding accuracy and quality and ensure the best environment to help each coder be as successful as possible, MiraMed also continuously scores both performance metrics and behavioral metrics for the duration of each coder's employment with the company. Data collection and monitoring have shown specific behavioral findings, including a correlation between the coder's ability to ask questions and high quality coding scores, and punctual arrival at internal meetings and training sessions and productivity scores.

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Are You Prepared for a Ransomware Attack?

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Imagine seeing the following message flash onto your computer screen: "Many of your documents, photos, videos, databases and other files are no longer accessible because they have been encrypted." What would you do?

That is the message computer users in more than 150 countries throughout the world saw on May 12, 2017 when their computers became infected with WannaCry, a ransomware program. The attack left several businesses, including many health organizations, scrambling to protect their data.

Although the number of WannaCry attacks in the United States was limited, this should be a reminder to all, especially healthcare organizations, to be prepared. The attack highlights the importance of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, which promote security of protected health information, and prudent computer and internet use.

Ransomware Defined

Ransomware is a type of malicious software used by hackers to encrypt the user's data and deny access to it until the user pays a ransom, usually in the form of a cryptocurrency like bitcoin. Hackers can also deploy ransomware that will destroy data.

In the case of the WannaCry virus, hackers exploited a known Microsoft Windows vulnerability and infected computers that did not have a security patch designed to fix the issue. The hackers encrypted the data and demanded $300 in bitcoin in order for it to be decrypted. By the second day, the amount went up to $600. After seven days, the data would be deleted.

Unfortunately, this is becoming a fairly common occurrence. According to a U.S. government interagency report, an average of 4,000 ransomware attacks occurred per day in the U.S. since early 2016. This marks a 300 percent increase from the 1,000 daily attacks reported in 2015.[1]

HIPAA Security Rule

Healthcare organizations are already required to follow HIPAA, which guards against the unauthorized access of electronic protected health information (ePHI). Specifically, the Security Rule establishes minimum technical, administrative and physical requirements that entities must follow in order to protect ePHI.

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Requirements include implementing a security management process to identify threats and vulnerabilities to ePHI, mitigating the identified risks, and creating procedures to guard against and detect malicious software.

One of the security management processes is a risk analysis. This type of analysis is the foundational element and first step in identifying and implementing safeguards required by the Security Rule. Methods vary depending on the entity's size, complexity and capabilities.

Information from the National Institute of Standards and Technology (NIST) details factors that entities should consider in designing a risk analysis. Factors to consider include identifying sources of ePHI—both within the organization and outside of it. Also, the plan should consider the human, natural and environmental threats to ePHI.

To assist in these endeavors, the Department of Health and Human Services Office of the National Coordinator for Health Information Technology (HHS ONC) has developed an online Security Risk Assessment Tool. Results from the risk analysis can be used to create policies for personnel screening; determine what data to back up; determine whether and how to use encryption; address what data must be authenticated to protect its integrity; and determine the appropriate manner of protecting ePHI transmissions.

Data Backup Plan

HIPAA also requires entities to create a data backup plan as part of an overall contingency plan to protect ePHI.

Requirements include a data backup plan that creates and maintains retrievable data and exact copies of ePHI. Also included is a disaster recovery plan for restoring any loss of data. Finally, an emergency mode operation plan details procedures to allow the continuation of critical business operations and protect ePHI while the system is in emergency mode.

In a fact sheet about ransomware attacks, HHS underscores the importance of maintaining frequent backups and ensuring the ability to recover data from those backups to effectively recover from a ransomware attack. According to HHS, "[t]est restorations should be periodically conducted to verify the integrity of backed up data and provide confidence in an organization's data restoration capabilities. Because some ransomware variants have been known to remove or otherwise disrupt online backups, entities should consider maintaining backups offline and unavailable from their networks."[2]

If a Ransomware Attack Occurs

HIPAA requires entities to have detailed procedures in place to use when responding to an attack in order to get back to "business as usual." The procedures should include ways to detect ransomware, how to conduct a risk analysis and ways to stop malware from spreading in the case of an attack. Post-incident activities should also include considering what, if any, type of notification is required by law, how the attack happened and if improvements need to be made in order to prevent it from happening again.

Employees should be educated on prudent computer and internet use. Employees should also be educated on ways to detect and respond to ransomware. Employees should know how to tell if an attack is occurring and what to do after clicking on something they later deem suspicious.

HHS recommends the following steps if an organization is the victim of a ransomware attack:

- Contact your FBI National Cyber Investigative Task Force immediately to report the event and request assistance. The task force will work with state and local law enforcement and other partners to pursue cybercriminals globally and assist the victims.
- Report cyber incidents to the US-CERT (United States Computer Emergency Readiness Team) and the FBI's Internet Crime Complaint Center.

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Organizations should also immediately contact their attorneys. Notifications to individuals, HHS and, in some instances, the media, under HIPAA should be considered very thoughtfully and with the assistance of counsel. The question of whether a ransomware attack amounts to a HIPAA breach is one of industry debate. Iliana Peters, a HIPAA compliance and enforcement official at the Office of Civil Rights (OCR), announced at a Georgetown University Law Center cybersecurity conference that OCR will "presume a breach has occurred" when a HIPAA covered entity or business associate is the victim of a ransomware attack. However, industry experts argue that this theoretical position does not marry with how a ransomware attack works in actuality. Nevertheless, an overarching conclusion cannot be drawn without considering the facts and circumstances of a particular attack or event. However, victims of ransomware attacks must be aware of this possibility and should consider this with their attorneys.

Ways to Protect Your Practice

The risk of a ransomware attack targeting a healthcare organization, especially a smaller one, is great. Ransomware attackers know that healthcare organizations are notoriously unprepared for such attacks, making them prime targets. As such, hospitals and medical practices should take care to conduct security risk assessments; fill in gaps, either through policy or technological improvements; adopt ransomware attack policies and educate their employees and staff on them; and purchase a cyber liability insurance policy to protect in the event a ransomware attack occurs. Now is the time to take action.

For the most current federal government information regarding ransomware attacks, go to www.us-cert.gov.

References:

[1] https://www.justice.gov/criminal-ccips/file/872771/download
[2] https://www.hhs.gov/sites/default/files/RansomwareFactSheet.pdf

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Note: The author extends special thanks to Amy Ryman, paralegal and executive administrative assistant at MiraMed, for her contributions to this article.

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The Case of the Wrongly Billed X-Rays: What Providers Can Learn

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Articles about coding appeals always seem to be about the facility or provider not getting paid. Have you ever wondered how coding impacts a *patient* when the proper codes are not used? The following example offers an interesting and useful case in point.

A nursing student fell at school and initially went to a teaching facility for care. The initial diagnostic exams were taken between November and December 2014. The patient was then referred to another teaching facility. She brought the results of the original diagnostic exams, which had already been interpreted and billed for by the first facility. The same exams were subsequently interpreted and billed for on November 3, 2015 by the second facility.

The patient underwent evaluation and management by a neurologist at the second facility, which included a physical exam, additional blood work and an EMG. The neurologist submitted the original diagnostic exams for a second reading, which were billed on November 3, 2015 with the same codes as the initial evaluation performed in 2014. The insurance carrier denied the second diagnostic billing as being out of network.

The patient appealed the case, stressing that the neurologist at the second facility had read the old radiologic films and that no new diagnostic radiologic studies had been done at the second facility. The appeal process continued until November 2016, when the patient was allowed to appeal by phone. She again stated that the diagnostic films billed in November 2015 were not new studies but a re-reading of the films taken in November-December 2014.

Ultimately, the case was decided in the patient's favor, with the insurer noting that the second facility's billing code should have been CPT® code 76140 (Consultation on x-ray exam made elsewhere, written report).

Per CPT Assistant 1997

CPT code 76140 (Consultation on x-ray examination made elsewhere, written report) is intended to be used when, for example, Doctor A from Sunnydale Hospital sends a radiograph taken at Sunnydale Hospital to Doctor B at Goodhope Hospital. Doctor A asks Doctor B to offer their opinion on the radiograph. Doctor B writes a formal report on their interpretation of the radiograph and sends a copy of this report to Doctor A.

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The Case of the Wrongly Billed X-Rays: What Providers Can Learn *(Continued from page 6)*

This code is not intended to be used by physicians within the same institution to re-read radiographs taken at that institution. Levels of Service (limited, intermediate, extended, comprehensive) include the "evaluation of appropriate diagnostic tests," which may require the attending physician to personally review the radiographs taken on their patient. However, the physician *cannot* use this code when the patient simply brings in the x-ray and the physician reviews and interprets the films. This service follows the same ideology as a consult service. (Remember the 3Rs of a consult: request opinion, render opinion, report opinion.)

However, when the patient brought their film studies to the neurologist for a second opinion, why were the films submitted to the radiologist for a review? Could the neurologist at this second facility not read the films as part of the consultation and therefore bill the appropriate evaluation and management, which would encompass the patient bringing in the diagnostic studies? As above, the physician *cannot* use this code when the patient simply brings in the diagnostic films and the physician reviews and interprets them.

CPT 76140, by definition, is a service that is utilized by a radiologist or other consultant who reads an x-ray (or any diagnostic imaging study) but does not actually see the patient. This is not used when a patient brings the film to a provider to simply review it as part of the patient's past record.

Understanding this, you might construe that you should or could bill for x-rays brought into the physician's office with the modifier -26 for professional component. *This is not the case*. When a patient brings x-rays into a provider's office, the films have already been read by the facility or provider who took them and should have the report attached. Even if the report is not attached, a provider may not bill for reading films that have already been read.

In certain circumstances in which the review of films takes more than 30 minutes, the proper code to bill would be 99358, which is the code for review of extensive records. However, this code would almost never apply, as most doctors do not spend that amount of time reviewing films. Therefore, unless 30 minutes or more were spent reviewing, the review of films should be neither separately coded nor reimbursed, but should simply be bundled into the exam and/or other services done the same day.

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From Surgical Codes to Telemedicine: Highlights of the 21st Century Cures Act

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The 21st Century Cures Act (Cures Act), signed into law on December 13, 2016, contains $6.3 billion in provisions that will fund federal agencies as they work to speed the arrival of diagnostic tools and disease therapies and improve mental health treatment. Some policymakers have proclaimed it the most important legislation passed in 2016.

According to former Vice President Joe Biden, "The 21st Century Cures Act is going to harness the best minds, science and technology to tackle some of the biggest healthcare challenges today. It gives millions of Americans hope."

Overall, the Cures Act represents an effort to achieve Medicare and Medicaid program savings while improving access to new technologies and healthcare services for program beneficiaries. The Cures Act includes important provisions relating to electronic health records (EHRs), medical research, mental health reform and telemedicine, in addition to several potentially high-impact Medicare reimbursement policy changes.

The Medicare reimbursement changes are set to take effect starting this year and into 2019, and include site-neutral payment exceptions, adjustments to the penalty calculation formula under the Hospital Readmissions Reduction Program, new codes to bridge outpatient and inpatient surgical procedures, and suspension of the 25 Percent Rule for long-term care hospitals (LTCHs).

Site-Neutral Payments

Prior to the Cures Act, the site-neutral Medicare reimbursement policy required the Centers for Medicare and Medicaid Services (CMS) to pay off-campus provider-based outpatient departments under the Medicare Physician Fee Schedule rather than the outpatient payment system.

The new site-neutral payment rules that became effective on January 1, 2017 under the Cures Act will reduce off-campus provider-based department claims reimbursement rates by about 50 percent, with three notable exceptions:

1. Off-campus provider-based departments that had already billed for covered services under the Medicare outpatient payment system before November 2, 2015 can still receive outpatient rates.
2. Hospitals with a "binding written agreement with an outside unrelated party for the actual construction of such department" dated before November 2, 2015 will be exempt.
3. Outpatient departments at cancer hospitals are exempt from site-neutral payment reductions.

Hospital Readmissions Reduction Program

Through the Medicare value-based reimbursement program, hospitals face up to a three percent payment cut if they have excessive readmissions (compared to a national mean readmissions rate) within 30 days of discharge for certain conditions.

Citing a December 2016 report from the Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE), critics of the program have argued that hospitals treating large proportions of dual-eligible beneficiaries, such as safety-net hospitals, are disproportionately penalized, since the patient population has higher readmission rates. That report stated that dual-eligible beneficiaries had 24 to 67 percent higher odds of a hospital readmission across conditions in the Hospital Readmissions Reduction Program.

In support of that position, the Medicare Payment Advisory Committee (MedPAC) has also recommended comparing hospitals with similar patient populations to each other, rather than a national mean readmission rate, to level the playing field.

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In response to these recommendations, starting in 2019, the Cures Act requires HHS to divide hospitals into groups based on similar dual-eligible beneficiary populations and apply "a methodology in a manner that allows for separate comparison of hospitals within each such group, as determined by the Secretary."

Surgical Procedure Codes

With the intention of building a crosswalk between Medicare inpatient and outpatient surgical codes, the Cures Act requires HHS to develop Healthcare Common Procedure Coding System (HCPCS) versions for no fewer than 10 surgical Medicare Severity-Diagnosis Related Groups (MS-DRGs) by January 1, 2018. More specifically, the Cures Act states that: "Not later than January 1, 2018, the Secretary shall develop HCPCS versions for MS–DRGs that are similar to the ICD–10–PCS for such MS–DRGs such that, to the extent possible, the MS–DRG assignment shall be similar for a claim coded with the HCPCS version as an identical claim coded with an ICD–10–PCS code."

While additional HCPCS codes do not explicitly change Medicare reimbursement policies, the new codes could impact the rates hospitals receive for common surgical procedures, considering that Medicare reimbursement for a short inpatient hospital stay is usually higher than similar outpatient stays. The creation of the additional crosswalk codes is consistent with steps CMS has already taken to prevent facilities from improperly billing for more lucrative short inpatient stays, most notably the Two Midnight Rule established in 2014 to curb hospitals from using short inpatient stays when the service should have been billed as outpatient.

Long-Term Care Hospitals and 25 Percent Rule Relief

The 25 Percent Rule designed by CMS in 2005 establishes a 25 percent limit on the proportion of patients an LTCH can admit from one hospital during the LTCH's cost reporting period. Under the rule, any LTCH that exceeded the 25 percent threshold would face Medicare reimbursement cuts. The rule would have reduced Medicare spending by $90 million, but some healthcare stakeholders, including the American Hospital Association (AHA), opposed the payment cuts. The AHA argued in October 2016 that the regulation "arbitrarily penalizes LTCH admissions based on the origin of an LTCH referral, with complete disregard for the patient's medical necessity for LTCH services."

Congress has delayed the 25 Percent Rule's implementation since the patient threshold was first finalized, and under the Cures Act, Congress extended the CMS enforcement prohibition of the 25 Percent Rule on LTCHs for another year.

Other notable provisions of the Cures Act include:

Electronic Health Records

"The development of new drugs and devices is meaningless unless they are delivered to the right patients at the right time," according to a House statement. "Cures will help improve delivery by ensuring electronic health record systems are interoperable for seamless patient care and help fully realize the benefits of a learning health care system."

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The reporting provisions of the Cures Act require that EHRs include criteria on product security, user-centered design and interoperability, and certification that the EHR conforms to testing.

The Cures Act also calls for a national Application Programming Interface (API) standard to cover authentication, security, auditability and deeper data interoperability, to be completed by stakeholders and published within one year.

In terms of enforcement, the law includes significant penalties for vendors who participate in information blocking—"that which interferes with, prevents or materially discourages access, exchange or use of electronic health information." Vendors can be fined up to $1 million per violation and would potentially lose their EHR certification if their EHR is not deemed interoperable.

Medical Research Initiatives

The Cures Act undoes two obstructive policies relating to medical research—one dealing with paperwork and the other with scientific meetings.

It eliminates the Paperwork Reduction Act requirements for National Institutes of Health (NIH) research—a step that will help speed research initiation and knowledge generation. The Paperwork Reduction Act of 1995 required multiple levels of government review and public comment on any set of questions that NIH researchers proposed to ask of 10 or more persons in a scientific study supported by contracts, the Intramural Research Program and many cooperative agreements.

This process rarely resulted in substantive changes, but could have delayed the start of research for up to nine months, dissuading investigators, especially trainees, from undertaking important studies. Cures Act provisions also support early-stage researchers. Today, the average age of a researcher receiving their first independent research grant from the NIH is 42. NIH has been working hard to create additional opportunities for younger researchers, including dedicated awards for new and early-stage investigators.

Though such efforts have proven valuable for encouraging individual researchers, they have not resulted in a lowering of the average age of independent investigators within the full NIH research portfolio. The Cures Act will establish an office at the NIH to promote policies aimed at improving coordination and analysis of opportunities for new and early-stage investigators, as well as to attract, retain and develop emerging scientists in priority research areas.

Such efforts will include strategies for developing early-stage researchers who are women or members of other groups that are traditionally underrepresented in biomedical research careers. To provide further support to early-stage researchers, the Cures Act authorizes the establishment of additional programs to assist in the repayment of student loans and raises the cap on the repayment assistance available to researchers.

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The Cures Act provides multiyear funding for three innovative scientific initiatives launched by the Obama administration: the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative, the Precision Medicine Initiative (PMI) and the Beau Biden Cancer Moonshot, which also includes a promising new research initiative focused on regenerative medicine.

Each of these initiatives has its own set of ambitious goals, but their basic aims are as follows:

- BRAIN is a sweeping effort to build technology and knowledge across an array of disciplines to elucidate how circuits in the brain function in real time and what goes wrong in disease.
- PMI is a transformative research infrastructure that will enable and simplify research across all diseases. Its centerpiece, dubbed All of Us, is a longitudinal cohort study involving one million or more Americans.
- The Beau Biden Cancer Moonshot is a plan to double the rate of progress in the fight against cancer, making more therapies available to more patients, while also improving cancer detection and prevention. The regenerative medicine component focuses on clinical research using adult stem cells, including autologous stem cells, and features an innovative funding mechanism that requires a match from the grant or contract awardee.

Mental Health

Text of the full Cures Act is more than 300 pages, with more than 100 pages dedicated to mental health reform, including the following directives aimed at improving mental health coverage and services:

- Creates a new presidentially-appointed and Senate-confirmed Assistant Secretary for Mental Health and Substance Use Disorders to oversee the Substance Abuse and Mental Health Services Administration (SAMHSA) and coordinate related programs and research across the federal government, with emphasis on science and evidence-based programs, and with the aid of a newly established Chief Medical Officer.
- Requires states to expend not less than 10 percent of their community mental health services block grant funding each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the individual's age at onset.
- Strengthens community response systems with a grant program to create databases on psychiatric beds, crisis stabilization units and residential treatment facilities.
- Directs CMS to outline for states innovative opportunities to use Medicaid 1115 waivers to provide care for adults with serious mental illness.
- Requires the Secretary of Health and Human Services to issue guidance clarifying the circumstances under which healthcare providers and families can share and provide protected information about a loved one with Social Media Information (SMI).
- Requires the Secretary to develop model programs and trainings for healthcare providers to clarify when information can be shared, and trainings for patients and their families to help them understand their rights to protect and obtain treatment information.
- Requires the Government Accountability Office (GAO) to conduct a study on parity enforcement and provide recommendation for increasing enforcement results.
- Provides for further guidance and compliance efforts in mental health parity to ensure insurance providers meet the spirit of the law.
- Requires the assistant secretary to award grants to implement suicide prevention and intervention programs for individuals who are 25 years of age or older, to include screening for suicide risk, suicide intervention services and treatment referrals.

The new law also establishes a coordinating committee of 23 individuals in order to provide "a summary of advances in serious mental illness and serious emotional disturbance research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of serious mental illnesses, serious emotional disturbances, and advances in access to services and support for adults with a serious mental illness or children with a serious emotional disturbance."

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It will also seek to determine what impact federal programs have on "rates of suicide, suicide attempts, incidence and prevalence of serious mental illnesses, serious emotional disturbances, and substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, preventable emergency room visits, interaction with the criminal justice system, homelessness and unemployment."

John M. Grohol, PsyD, founder of Psych Central, a mental health and psychology network, stated in a recent article that "While this bill goes a long way to addressing some of the problems with the mental healthcare system in the United States, it does little to fix the underlying issues. It does not significantly increase the actual funding to states that provide public mental health care to the indigent and poor. And it doesn't really do much to help bridge the divide between physical healthcare (delivered through primary care physicians) and mental health, although the new bill does carry a number of provisions to start addressing this issue."

However, the White House lauded the bill for taking steps to "improve mental health, including provisions that build on the work of the President's Mental Health and Substance Use Disorder Parity Task Force. Like all comprehensive legislation, the bill is not perfect. But the legislation offers advances in health that far outweigh these concerns."

Telemedicine

Medicare coverage of telehealth is currently limited to patients seen at certain clinical facilities, so-called "originating sites" located in health professional shortage areas (HPSAs) or outside of Metropolitan Statistical Areas (MSAs).

Originating sites do not include the patient's home, and telehealth services are primarily limited to professional consultations, psychiatry services and certain end-stage renal disease (ESRD) services. Medicare coverage does not include remote patient monitoring either in the home or other care settings.

Although the statute allows the HHS Secretary to expand coverage to other services, CMS has been very cautious in adopting new telehealth codes. In January, the American Telemedicine Association stated that Medicare does not provide enough billing codes for telehealth services and lobbied for 35 new codes to be added to the Physician Fee Schedule.

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To further clarify its intent, the Cures Act also includes the following "Sense of Congress" language.

It is the sense of Congress that:

1) Eligible originating sites should be expanded beyond those originating sites described in 42 U.S.C. 1395m(m); and
2) Any expansion of telehealth services under the Medicare program should:
    A) Recognize that telemedicine is the delivery of safe, effective, quality health care services, by a health care provider, using technology as the mode of care delivery;
    B) Meet or exceed the conditions of coverage and payment with respect to the Medicare program if the service was furnished in person, including standards of care.

Section 4012 of the Cures Act makes no change to current Medicare coverage of telehealth, but it does require the Medicare Payment Advisory Commission (MedPAC) and CMS to study the issue and submit information to the congressional committees of jurisdiction. By no later than March 15, 2018, CMS must identify and report on those populations of Medicare beneficiaries whose care may be most improved through telehealth expansion, including dual eligibles and those with chronic conditions, and make recommendations regarding how those telehealth services covered by private payers could be included in the Medicare fee-for-service program. It must also report on telehealth activities taking place in the Center for Medicare and Medicaid Innovation (CMMI) and those funded through Section 1115A of the Social Security Act.

It is estimated that 90 percent of large companies already have integrated telemedicine solutions and that by 2020, telemedicine will be a $34 billion industry. Additionally, a recent study by the Federation of State Medical Boards found that telemedicine is currently the most important medical regulatory topic to be addressed. The studies called for in the new legislative directives, along with the Federal Communications Commission's efforts to fund the buildout of telemedicine networks and explore additional broadband-enabled healthcare solutions, are likely to further encourage telemedicine's adoption and reimbursement.

Summary

The Cures Act addresses a very broad spectrum of healthcare issues, attempting to strike the proper balance between controlling healthcare costs and ensuring patient access to new technologies and quality healthcare. As Congress and CMS continue their efforts toward that goal with this bill and others sure to follow, it is important for stakeholders to remain fully informed and prepared for changes that could impact both revenues and investments and to engage in the legislative process as opportunities arise.

Gregory R. Zinser, Vice President at Anesthesia Business Consultants, has a broad range of experience in healthcare finance and administration. Mr. Zinser's recent experience includes four years as CEO of one of the nation's largest anesthesia billing and practice management companies, and CEO of the management company for one of the nation's largest anesthesia groups. With experience in all facets of anesthesia practice management, Mr. Zinser brings strength and depth to a team that has become the industry standard in both responsiveness and quality of resources. Mr. Zinser can be reached at greg.zinser@anesthesiallc.com.

The groundwork of all happiness is health.

Leigh Hunt

Coding Case Scenario

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Direction: Apply the appropriate codes for principal diagnosis, secondary diagnosis and procedure to the following case. Answers can be found at the end of the newsletter.

This is an emergency department facility coding:

History of Present Illness

A 26-year-old man was trying to rob a car parked on the sidewalk, when a K9 police officer caught him in the act. He tried to run, but the police officer unleashed the dog, and he sustained multiple dog bites in his left lower leg. He was brought to the emergency department for medical intervention.

Review of Systems

All systems are reviewed and negative except as marked: Skin - Multiple jagged bites in the left lower leg. Painful open wound in left lower leg.

Past Medical History

- Personal History: Gastritis and cellulitis
- Past Surgical History: none
- Social History: Never smoked

Physical Examination

- General: Alert, oriented X3, no acute distress, well developed, well hydrated.
- Head/Eyes: Atraumatic, normocephalic, EOMI.
- ENT: Atraumatic, moist mucous membranes.
- Neck: Supple/no meningismus, non-tender, full range of motion, no JVD.
- Respiratory/Chest: Atraumatic, no distress, no tenderness, normal breath sounds.
- Cardiovascular: Regular rate and rhythm, normal heart sounds, normal capillary refill.
- Abdomen: Atraumatic, normal bowel sounds, soft abdomen, no CVAT to percussion.
- Back: Atraumatic, normal inspection, full range of motion, painless range of motion.
- Skin: Multiple open wounds in left lower leg of different sizes. Positive erythema around each wound. Tenderness to palpation.
- Neurological: Alert, oriented X3, normal speech, no motor deficits.
- Psychiatric: Patient is in pain distress, otherwise normal psychiatric assessment.

Procedure Note

Operative consent obtained, left lower leg was anesthetized locally using lidocaine and epinephrine and prepped in usual sterile fashion. Despite multiple open wounds, we only directed our attention toward the largest wounds.

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Coding Case Scenario *(Continued from page 14)*

Wound 1: Using nylon suture, 1.4 cm wound was closed with three stiches in simple manner.
Wound 2: Using nylon suture, 1.5 cm wound was closed with four stiches in simple manner.
Wound 3: Using nylon suture, 1 cm wound was closed with no other issues. The patient tolerated the procedure very well.

Medical Decision Making

MD performed a simple laceration repair using nylon suture for the three largest lacerations in left lower leg measuring 1.4 cm, 1.5 cm and 1 cm. The patient was apprehended by the police officer right after giving the discharge instructions.

Primary Impression: Multiple open wounds of the left lower legs.

Secondary Impression: Dog bite

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Medical Coding Summer Checkup: Missing Documentation Heats Up

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As we move toward the end of summer, MiraMed is experiencing a common seasonal trend—a wave of missing documentation that is creating the need to "surf" through work and modify in order to properly code medical claims and send them to payers in a timely fashion. MiraMed's health information management and coding professionals work hand in hand with clients to gather all of the appropriate medical documentation needed to translate that documentation into reimbursable population health data and medical coding data.

Most of the information from the clinical teams on the millions of charts coded each month finds its way appropriately into the charts and is ready for coding.

However, in some cases, documentation that is missing some of the appropriate clinical diagnoses and procedures prevents the chart from being "code complete." These records must be put on hold or "pended" until the appropriate documentation is obtained. That pended queue tends to swell in summer (and during the year-end holiday season), due primarily to a missing discharge summary, a missing order or incomplete documentation.

Most organizations have established processes in order to review these statuses; however, these processes are often designed to manage workflow rather than reduce the submission of claims with missing documentation. MiraMed's client service managers work proactively with the company's partner hospitals to lower the volume of charts that cannot be coded and billed due to this lack of information.

Manual processes for creating documentation and generating data with traditional applications such as Excel can increase the time required to manage a file and may increase the risk of inaccuracies as well.

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Medical Coding Summer Checkup: Missing Documentation Heats Up *(Continued from page 15)*

MiraMed encourages clients to automate their documentation and coding workflow. This automation can help eliminate errors, shorten chart turnaround times required to achieve "code complete status," and reduce delays due to missing or incomplete documentation, scanning and paper filing.

In addition to automation, MiraMed also strongly recommends reviewing processes to limit potential delays while the patient is still in the facility as well as reviewing documentation and coding workflow routinely to identify and resolve the root causes of problems. These root causes can include deficiencies in knowledge and training, problems with EHR configuration and inadequate processes.

By developing a plan to address each root cause and working concurrently to reduce those root causes, organizations will see a reduction in allocation of resources for pending claims, improved compliance with documentation standards and best practices, fewer bill-holds and more timely filing. These overall improvements in the medical record will benefit the patient, the organization and the community the organization serves.

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Acquired Immune Deficiency Syndrome: Clinical and Coding Perspectives

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Clinical Perspective

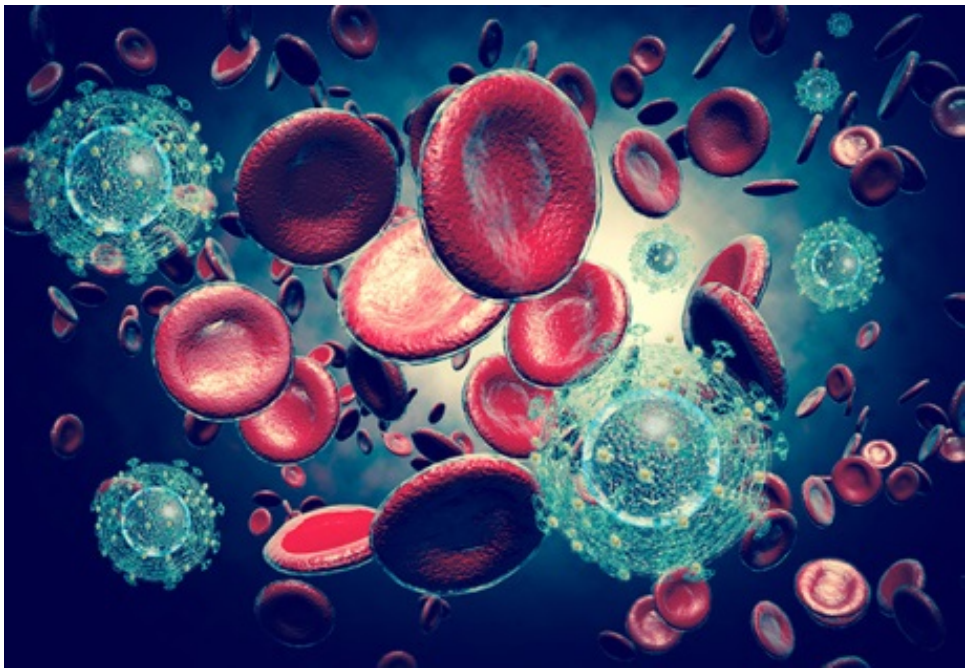
Acquired Immune Deficiency Syndrome, also known as AIDS, is characterized by gradual destruction of helper T-lymphocytes, which play a role in immunity and autoimmunity. The destruction will cause the patient to be susceptible to opportunistic infections, cancer and other abnormalities. This is caused by human immunodeficiency virus (HIV), which can be transmitted via contact with infected blood, semen, vaginal secretions or other body fluids. Acquiring the illness can be associated with identifiable high-risk behaviors.

An individual in whom the virus is present is referred to as HIV positive (asymptomatic). If the patient marked with active infection has clinical manifestations and complications (symptomatic), the HIV positive patient has developed AIDS.

The diagnosis of AIDS includes one or more of the following test results:

a. A blood test for HIV antibodies such as enzyme-linked immunosorbent assay (ELISA). A positive result is followed by a confirmatory test, the Western blot test, to detect the presence of HIV antibodies, which indicates HIV infection.
b. CD4+ T-cell count is less than 200 cells/ µl.
c. Conditions specified by the Centers for Disease Control and Prevention (CDC) as categories A, B or C are present.

Repeated opportunistic infections, such as cytomegalovirus infection, pneumocystis carinii pneumonia, toxoplasmosis and Kaposi's sarcoma can develop.



Antiviral drugs, ideally a combination of three to five drugs, can be used as primary therapy to try to gain the maximum benefit of reducing HIV viral replication with the fewest adverse reactions, but these drugs do not kill the virus. Immunomodulatory agents to boost the immune system that has been weakened by AIDS and retroviral therapy may be used as additional treatment. The physician might order anti-infective and antineoplastic agents to combat opportunistic infections and associated cancers. Supportive therapy such as nutritional support, fluid and electrolyte replacement therapy, pain relief and psychological support can be used as management.

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Acquired Immune Deficiency Syndrome: Clinical and Coding Perspectives *(Continued from page 17)*

Coding Perspective

Coding professionals can only code confirmed cases of HIV infection/illness. This is one of the exceptions to the hospital inpatient guidelines. In the inpatient setting, HIV is the only condition that must be confirmed to select the code. All other conditions documented as "probable," "suspected," "likely," "questionable," or "still to rule out," are coded as if they exist in the inpatient setting. The physician must clearly document the diagnosis of the patient as HIV positive or as having an HIV-related illness.

If a patient is admitted with an HIV-related condition and the patient also has HIV, the selection of principal diagnosis should be B20, human immunodeficiency virus (HIV) disease followed by the diagnosis of the HIV-related conditions.

Following are the common codes related to HIV:

- B20, Human immunodeficiency virus disease
- Z21, Asymptomatic human immunodeficiency virus infection status
  - Use this code if the HIV is asymptomatic
  - Common terms are “HIV positive,” “known HIV,” “HIV test positive”
- R75, Inconclusive laboratory evidence of human immunodeficiency virus
  - Use this code for inconclusive HIV serology but no definitive diagnosis or manifestations of the disease
- Z11.4, Encounter for screening for human immunodeficiency virus
  - Use this code when a patient is seen to determine his/her HIV status
- Z71.7, Human immunodeficiency virus counseling
- O98.7-, Human immunodeficiency virus disease complicating pregnancy, childbirth and the puerperium
  - Use this code for a pregnant patient noted to have symptomatic/asymptomatic HIV followed by code B20 or Z21, accordingly.

References:

- ICD-10-CM Official Guidelines for Coding and Reporting, 2017.
- Gould, B. and Dyer, R. *Pathophysiology for the Health Professions*, 4th edition.

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Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

World Health Organization

Coding Case Scenario Answers

	Code	Code Description
Principal Diagnosis	S81.852A	Open bite, left lower leg, initial encounter Alphabetical Index of DISEASE main term: Bite →Leg (Lower). "Lower" is already a NON-ESSENTIAL ELEMENT for this sub-term. This does not affect the code assigned.
Secondary Diagnosis	W54.0XXA	Bitten by dog, initial encounter Alphabetical Index of External Cause main term: Bite → Dog. Always code to higher Level of Specificity based on the given documentation.
Secondary Diagnosis	Y35.893A	Legal intervention involving other specified means, suspect injured, initial encounter. Alphabetical Index of External Cause main term: Legal → Intervention → Specified Means → Injuring → Suspect (Suspect, since the patient was caught in the act of robbing a parked car by the K9 Officer). Can code Multiple External Codes to fully describe the scenario given in the documentation.
Secondary Diagnosis	Y93.89	Activity, other specified – patient is trying to rob a parked car. Alphabetical Index of External Cause main term: Activity → Specified NEC. There is no specific code for "robbing a car" in the ICD-10 code book but still there is a given activity scenario in the documentation, so we need to code the Activity using the most suitable code.
Secondary Diagnosis	Y92.480	Sidewalk as the place of occurrence of the external cause – Patient was trying to rob a car parked in the SIDEWALK. Alphabetical Index of External Cause main term: Place →Sidewalk Code to the highest level of specificity. Remember that the ICD-10 provides numerous specific codes for place of occurrence. (Home: can be kitchen at home, bedroom at home, etc.)
CPT Procedure	12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm Per procedure notes, the MD sutured the largest among the multiple open wounds. He decided to suture three different wounds using simple repair. Since three different lacerations were repaired with the same complexity of repair on the same group of anatomical parts, Guidelines for laceration repair of the CPT will apply: Add all wound lengths of the same complexity classified in the same anatomical group of the CPT.