

ADMINISTERING HEALTHCARE VIA TECHNOLOGY

Donna Myers RN, CCS

In light of the current COVID-19 public health emergency, the healthcare industry is evolving by virtually connecting patients with physicians, no matter the time of day or location of the patient. Telehealth is one strategy to help flatten the curve of infectious diseases: by not congregating in small spaces like waiting rooms and keeping healthcare providers apart from patients. The current ongoing crisis makes virtual medical care an indispensable tool across the United States.

Types of Virtual Medical Care

In regards to the growth of telemedicine, more than half of all U.S. hospitals currently have a program in place[1]. The global telemedicine technologies market, including hardware, software, and services, was valued at \$17.8 billion in 2014 and is predicted to grow at a compound annual growth rate of 18.4% from 2014 to 2020[2]. The three states with the highest telemedicine adoption rates are Alaska (75%), Arkansas (71%), and South Dakota (70%), likely due to rural areas [3].

“Telemedicine” is an all-encompassing term coined in the 1970’s, which means “healing at a distance”. per World Health Organization (WHO). Examples include digital transmission of medical imaging, remote medical diagnosis and evaluations, and video consultations with specialists [4].

1. Teresa Lafolla <www.blog.evisit.com/36-telemedicine-statistics-know>.
2. Id.
3. Id.
4. <https://www.who.int/goe/publications/goe_telemedicine_2010.pdf>.

continued on page 2 . . .

INSIDE THIS ISSUE:

Administering Healthcare Via Technology Pages 1 - 2

Understanding Critical Care Coding Page 3

Intracranial and Intracerebral Hemorrhages Page 4 - 5

NOTE FROM DR. HUSTY

I will keep my comments brief, but I wanted to thank everyone in the MARSI Family for sticking together during COVID-19.

Essentially, we have only had one employee with a close call and luckily the test was negative. In an effort, to support our MARSI Family, we did make N95 masks available to all our employees and their family to keep them safe. As we feel this is very important for our MARSI Family, but also for all the communities across the country! Masks save lives as well as hand washing and social distancing!

We do see a return to normal on the horizon, but more importantly, I am just so happy to be a part of such a wonderful family.

We still have some COVID-19 challenges ahead of us, but at least, we can lean on each other.

Thank you for being there.

Todd M. Husty, D.O. President and Chief Medical Officer of Medical Audit Resource Services, Inc.

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continued from page 1

“Telehealth” is defined by the Health Resources and Services Administration (HRSA) of the United States of Health and Human Services (HHS) as the utilization of electronic information and telecommunications technologies to support and promote long-distance clinical healthcare, patient and professional health education, public health and health administration. Telehealth expands beyond telemedicine and includes non-clinical events such as appointment scheduling, continuing medical education, and physician training [5].

There are many medical specialties of telehealth, such as: teleradiology, telepsychiatry, teledermatology, etc.

“Telecare” relates to technology that enables patients to maintain their independence and safety while remaining in their own homes. This technology includes mobile monitoring devices, medical alert systems, and telecommunications technology like computers and telephones. Services may be provided through audio, text messaging, or video communication technology, including Skype, FaceTime, or Zoom videoconferencing capabilities. Continuous remote monitoring of patients enables telecare to track lifestyle changes over time as well as receiving alerts relating to real-time emergencies [6].

“Teleconsultation” is a general term for any consultation between doctors or between doctors and patients on a network or video link (e.g. Facetime, Skype, Internet, etc.) [7]

How to Use Virtual Medical Care

In order to take advantage of the use of telemedicine, first contact your healthcare provider and check with your insurance carrier.

For beneficiaries with Florida Blue, TELEDOC membership is available, which is 24/7/365 access to doctors by phone or video. A Digital Health Directory can be found at www.techhealthdirectory.com. For more information on FLORIDA BLUE telehealth, visit <https://www.floridablue.com/virtual-health>.

Regarding Medicare beneficiaries, the Coronavirus Preparedness and Response Supplemental Appropriations Act, signed into law on March 6, 2020, includes a provision allowing waiver of certain Medicare telehealth payment requirements to allow beneficiaries in all areas of the county to receive telehealth services. In response, on March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility [8]. For more information on the new Medicare waiver, visit: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html>.

Additional examples of telemedicine/telehealth organizations include MediOrbis, Chiron Health, Inc., American Telemedicine Association, MDLIVE, Doctor on Demand, Inc., and American Well.

Why Use Telemedicine?

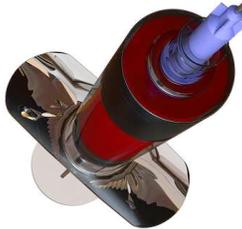
Telemedicine has gained significant traction over the last few years. More importantly, during these critical times, virtual medical care is found to be the “most valuable resource during a pandemic as it allows patients to be cared for without putting healthcare providers or others at increased risk for spread of diseases [9].” According to Jonathan Wiesen, MD, Founder and Chief Medical Officer of MediOrbis, telemedicine has become a resourceful utility as a “time-and cost-efficient alternative to brick-and-mortar medicine [10].” Dr. Wiesen continued saying “People are never going to stop seeking in-person services, be it in medicine, shopping, or education. However, I believe that this moment is a wake-up call for people to see the great value that remote medical services-telemedicine-offers, and that it is indeed time-and cost-efficient [11].”

References:

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10. Id.
11. Id.

UNDERSTANDING CRITICAL CARE CODING

Molly Snowberger, RHIA, CCA



There are several key elements to consider when reporting critical care services. Although there are only two codes for adult critical care, 99291-Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, and 99292-each additional 30 minutes, confusion about how to properly report critical care services still persists amongst coders. Keeping in mind there are many rules, guidelines and definitions that should be followed when determining if a service is medically necessary; understanding what qualifies as critical care is “critical” to the assignment of the correct codes.

First, patients who meet the definition of critically ill often require medical care from various providers and specialists throughout their hospital stay, and critical care codes 99291 and 99292 should only be reported once per day by providers within the same medical group and specialty. However, providers of different specialties can separately report critical care coding hours if the documentation supports different critical conditions being treated within a different timeframe.

Secondly, critical care codes are assigned based on the time spent providing E/M services to critically ill and/or critically injured patients. Documentation in the medical record must clearly indicate the total amount of critical care time spent. If critical care services are provided for less than 30 minutes, the appropriate site-of-service E/M code should be reported instead. Critical care time includes face-to-face time, time spent on the unit or floor where the provider is immediately available to the patient and any other procedures or services performed on the same day that are bundled with the critical care codes. Procedures performed on the same day that are not bundled within the critical care code itself should be reported separately.

Thirdly, although critical care is time-based, it is certainly not the only other factor to consider in reporting critical care services. The documentation itself must also meet the definition of critical care. Critical care involves high-complexity medical decision making to prevent further decline in the patient’s condition. According to Current Procedural Terminology (CPT), “A critical illness or injury acutely impairs one or more vital organ system(s), such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition.” Both the severity of the patient’s illness and/or injury and the treatment rendered must be met to qualify for critical care. It is important to note that providing medical care to a critically ill patient does not constitute billing a critical care service. It is the treatment and management of the patient’s condition during the encounter that determines the appropriate service(s) to report.

Fourthly, unlike other E/M service codes, critical care codes are not assigned based off of the site/location of service. Although critical care is typically provided in the ICU, the patient is not required to be located in a critical care area to receive critical care services (e.g., critical care could occur in an observation unit or emergency room, etc.).

Lastly and foremost, the patient must be critically ill and/or injured at the time of the encounter for the provider to report critical care codes; therefore, if the patient’s condition has changed from critical to stable, it would not be appropriate to continue reporting critical care services. Instead, the appropriate E/M site-of-service code should be assigned. The provider should always have clear documentation of the type of care being provided regardless of the location. If the documentation is not clear, the coder should query the provider for clarification.

* Please note, this article focuses on adult critical care coding only. There are specific codes to be utilized when billing/coding critical care services for children and infants and the guidelines are significantly different.



INTERCRANIAL AND INTRACEREBRAL HEMORRHAGES

Nancy Keenan, RN, CPC, CCS

Intracranial hemorrhage are those that occur within the meninges and include epidural, subdural, and subarachnoid hemorrhages. Intracerebral hemorrhages are those that occur within the brain tissue or the ventricles.

Symptoms and prognosis depend upon the size and location of the hemorrhage. Hemorrhages can result in increased intracranial pressure with resulting brain herniation. Cushing's triad (hypertension, bradycardia, and abnormal respirations) is a late sign of increased intracranial pressure and indicates that brain herniation is imminent.

Diagnosis is by CT, although a lumbar puncture is used if the patient has a negative CT and is suspected of having a subarachnoid hemorrhage. Initial management includes assessing the following: ABC's (Airway, Breathing, and Circulation), Glasgow Coma Scale, and pupillary size and reaction. The Glasgow Coma Scale is used to assess the level of consciousness and the extent of injury to the brain. Treatment involves controlling intracranial pressure, lowering blood pressure, administration of seizure medication either to treat or prevent seizures, or surgery. Observation and monitoring with follow up CT scans are for bleeds that are small with no or minimal symptoms, which will reabsorb over time.

Epidural/Extradural Hemorrhage (**S06.4X-category** for Traumatic and **I62.1** for Nontraumatic)

- Occurs between the skull and the dura mater
- Mostly caused by trauma
- Nontraumatic causes are very rare and include infection/abscess, coagulopathy, hemorrhagic tumors, and vascular malformations
- Most are due to bleeding from the middle meningeal artery
- Treatment includes: Surgical management (craniotomy with evacuation of the hematoma, Burr hole evacuation, or monitoring if the bleed is small and meets certain parameters)

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Epidural/Extradural Hemorrhage (**S06.4X-category** for Traumatic and **I60** for Nontraumatic)

- Occurs between the arachnoid and pia mater
- Traumatic causes are from head injuries, and non-traumatic/spontaneous causes are from a ruptured cerebral aneurysm or an arteriovenous malformation. AVM's and aneurysms are responsible for hemorrhagic strokes.
- Surgical treatment of an aneurysm includes clipping or endovascular coiling. AVM's are treated with endovascular embolization, stereotactic radiosurgery, or surgical removal.
- Treatment is also initiated to control vasospasm and hydrocephalus.

INTRACRANIAL AND INTRACEREBRAL HEMORRHAGES

Nancy Keenan, RN, CPC, CCS

continued from page 4

In Risk Adjustment, these conditions can sometimes be coded as current when they are clearly a history of. If the patient underwent surgical intervention or if the imaging studies are available and the hemorrhage is no longer present, then it should be documented and coded as a history of.

It is important for the provider to accurately document the condition as current or history of with specific information regarding current treatment and any sequela that may be present in order for the coder/auditor to make a determination if the condition was coded correctly or if a query is required for clarification.

Providers often need education regarding the 7th character options for injuries. In addition, information is not always clearly documented as to what the current treatment is on the DOS that is being reviewed.

Providers should not document and code acute conditions from a previous hospital stay in the current encounter unless the condition is still present on that date of service. Treatment should be linked to the condition or the status of the condition (resolving) should be documented.

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