Cal Ortho On-Line

Orthopaedic Issue Briefs

FROM THE COA

California Orthopaedic Association

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IN THIS ISSUE

ICD-10-CM Compliance White Paper

Several things have become clear in the implementation of ICD-10-CM:

1. There is no one implementation strategy that fits all orthopaedic practices.
2. The documentation of the service rendered must be improved and is critical to help your billing department select the correct ICD-10-CM code.
3. If you are using an EMR company, make sure that their system is detailed enough to get you to the correct billing level.
4. End-to end testing is important to help avoid payment delays.

COA has prepared the attached ICD-10-CM Compliance White Paper to provide our members with resources to help with their implementation. There are many practical resources that could be valuable to orthopaedic practices of all sizes. The resources include "ICD-10 Documentation Tips" prepared by AHIMA that will help improve your documentation.

Accountable Care Organizations in California

Now that the U.S. Supreme Court has upheld subsidies for federal exchange programs, it is timely to review Accountable Care Organizations and how they are changing the health care delivery system in California. Integrated Healthcare Association (IHA) has released a series of briefings on various aspects of ACO arrangements in California.

The issue briefings include:

1. **A Large Community Health Center Adapts to a Changing Insurance Market:**
   AltaMed, founded more than 40 years ago as a free clinic serving the Latino population in Los Angeles and Orange Counties, has experienced enormous growth from $15 million 20 years ago, to $400 million in 2014. They serve 70% Medi-Cal patients, 23% commercial insurance included Covered California, and 3% seniors with Medicare Advantage. **Read Briefing . . .**
2. **Referral Management and Disease Management in California's Accountable Care Organizations**
   Medical groups in California are seeking to extend care management capabilities for patients enrolled in commercial HMO and Medicare Advantage with Prescription Drug plans to consumers who have chosen commercial PPO and Medicare FFS coverage. **Read Briefing . . .**
3. **Accountable Care in California: Imperatives and Challenges of Physician-Hospital Alignment**
   Close collaboration between medical groups and hospitals, often sealed through joint ownership arrangements, can improve data transfer, reduce duplicative testing and promote smooth patient transitions from ambulatory to inpatient, post-acute and community settings. Hospitals can serve as strategic partners for medical groups, offering the financial capital and managerial expertise needed to succeed in a complex environment. **Read Briefing . . .**
4. **ACO Contractual Arrangements in California's Commercial PPO Market**
   Meaningful alignment between ACO and health plans presents challenges for both the ACO and its health plan partners—including patient attribution, data exchange, risk sharing arrangements, and unclear responsibilities for care management. This issue brief examines these contractual arrangements within commercial PPO markets in California. **Read Briefing . . .**

Calendar of Events

COA Mandatory QME Report-Writing Course
Pacifica Orthopedics—Huntington Beach
September 11-12, 2015
Register for the course

COA's 2016 Annual Meeting/QME Course
Ritz-Carlton Laguna Niguel
May 19-22, 2016
Make your Hotel reservations

IN THIS ISSUE

The Perils of Cut-and-Paste Documentation

Not only is the practice of copying a block of prewritten text and pasting it into a patient record a questionable billing practice, it also creates the potential for adverse patient outcomes.
Read why . . .

Solutions Guide: Population Health June 2015

Consider these four analytic integrations at the point of care for population health

By Brian Drozdowicz, Senior Vice President and General Manager, Global Population Health, Caradigm

We know that integrating analytics at the point of care contributes significantly to population health success. But which integrations should your organization tackle first? Consider these four:

1. **Real-time data**:
   In population health, it's critical that staff work as efficiently as possible, making proactive decisions based upon solid and timely information. As such, analytics should work against real-time data to ensure that health organizations are focusing on the right patients at the right time. For example, consider the discharge of a congestive heart-failure patient who has been a frequent visitor to the emergency room. Knowing exactly when the discharge occurs in order to take proactive action to prevent complications and near-term readmissions is an effective way to both improve the patient's health and manage costs.
2. **Risk stratification**:
   Employ risk stratification to drive care management processes. When closely integrated into a care manager's workflows, he/she can be notified of risk scores and then take immediate action. Risk stratification is an important tool to allow care managers to focus on patients that have the highest return on intervention. Traditionally, as risk scores changed, they bounced between spreadsheets or other software systems that don't talk to each other. That resulted in a tremendous amount of manual intervention – and increased odds for manual errors. Automate risk stratification so that a score that passes a given threshold is routed directly to the appropriate care manager for immediate action. This forces a consistent approach for all patients and is an extremely effective means of ensuring consistent care – one of the core tenants of accountable care.
3. **Clinical workflow tools**:
   Integrate analytics with clinical workflow tools to identify care gaps in standard quality measure steps (ACO33, HEDIS, PQRS, etc.) and facilitate the closure of those gaps. Consider the diabetic who needs annual eye and foot exams. Integrating this information into a workflow saves time and is much more effective than if that information was sitting in a standalone spreadsheet or other system. Automating the workflow in value-based settings is a simple way to ensure that physicians are providing quality care through a consistent approach and are rewarded appropriately.
4. **Automated communications**:
   Integrate quality-improvement data with automated tools, such as text messages, emails, or integrated voice response, to close care gaps. This is more cost effective than using clinicians to make patient phone calls. Their time is better spent focusing on caring for sick patients rather than attempting to close gaps in care. That's where automated systems, based upon patient preferences, come in. These technology-based approaches can motivate patients to take actions with the same results and at lower costs.

While you may also wish to consider other analytic integrations at the point of care, these four are an excellent place to begin.

Clinically Integrated Networks and Population Health: Taking the Next Step

Healthcare organizations increasingly face the demands of value-based reimbursement as hospitals and physicians are held accountable for higher quality delivered at a lower cost. As organizations plan and prepare for value-based care, they also must remain focused on margins threatened by increased cost structure and declines in reimbursement in the current fee-for-service environment. Caradigm, a healthcare analytics and population health company, has developed a briefing paper discussing these challenges.
Read Briefing ...

IN THIS ISSUE

OIG Issues Fraud Alert on Physician Compensation

On June 9, 2015, the Office of Inspector General of the Department of Health and Human Services (OIG) issued a fraud alert warning that physician compensation arrangements may violate the federal anti-kickback statute. The alert warns doctors entering into payment arrangements, such as medical directorships, that their compensation must reflect fair market value for services provided. It's becoming more common for doctors to be employed by hospitals and other organizations as medical directors, but those arrangements might violate anti-kickback law when their purpose is to get more referrals from those doctors. "Although many compensation arrangements are legitimate, a compensation arrangement may violate the anti-kickback statute if even one purpose of the arrangement is to compensate a physician for his or her past or future referrals of federal healthcare program business," according to the alert. The OIG took the opportunity to publicize that it recently settled cases against 12 physicians who entered into medical director agreements and other arrangements which the OIG believed were for compensation to induce the physicians to refer or direct business to the entity paying the compensation to the physicians. Read the Health Law Alert prepared by Hooper, Lundy & Bookman . . .