Care2Learn Online Education for Healthcare

THERAPY REPORT

Volume 1, Issue 6

Clinical Care for Therapy

Documentation Tips for Clinical Re-Certifications

What is clinical justification? What is it that needs to be justified?

Q. What is the payer source looking at and/or looking for?

A. The payer source is looking for:

- Functional comparison from time of evaluation to discharge
- Evidence of caregiver training
- Specific skilled interventions rendered to the patient during treatment, not just the names of the CPT codes rendered
- If the patient is being discharged, mention the expected discharge location, and whether the patient will be functioning alone, or supervised and how/or what you expect the patient to be able to perform within that environment.
    - For example: Pt. D/C to home with spouse. Pt. requires CGA for transfers and gait with own FWW. Spouse has been trained to provide needed assistance. It is recommended that Pt. continue PT/OT with home health services.
- If the patient dies or returns to the hospital, record all of the above data to support the claim for the services rendered to date

For the payer source to agree to pay for more services they need to see proof within the documentation that justifies the services already rendered, in addition to a clinically-justified reason to continue skilled services. The dictionary definition of justify is "to show to be just, to be right." Justification is **not** too much to ask for in order to continue to pay for a rehabilitation that may easily be wiped out tomorrow through another stroke, hip fracture or natural deterioration.

Ask yourself the following questions when writing a re-certification:

- Does your documentation offer justification for the services already rendered?
- Does it demonstrate progress towards a functional objective?
- Does it demonstrate that every effort has been made to ensure continuation of the functional progress attained?
- Does the documentation show the potential for future improvement?
- Would ***you*** pay for more therapy services based solely on the documentation without a first-hand look at the patient?

Clinical Justification is the reason behind the majority of all financial denials.

Clinical Resource Services, LLC

Documentation for Re-Certifications

Dysphagia Coding and Documentation

Group Treatment: Arthritis

Compliance in the Cloud

Denial Code 20

Pediatric Boost for Immunizations

***Your* choice for quality and expertise**

Inside this issue:

CPT Coding and Documentation for 92526 Treatment of swallowing, dysfunction and/or oral function for feeding, individual, *Part I*

Documentation for this code should include at least one item from each of the rows within the corresponding table below:

Pre-Feeding

Pt performed
• increased ability to tolerate presentation of food • increased tolerance to texture of food/liquids • increased opening of oral cavity • control of head/neck positioning during P.O. intake • attending to feeding task • decreased distractibility/inattention to food/liquid during P.O. intake • minimized bite reflex
• *(specify percent)* of the time • with *(specify percent)* accuracy • by *(specify percent)*
using
• verbal description/identification of foods presented • manual massage of oral cavity • correct wheelchair/dining chair seating position *(specify position and adaptive equipment)* • correct bed position *(specify position and adaptive equipment)* • controlled environmental techniques *(specify)*
in preparation for safe and efficient P.O. intake and progression of swallowing.
(Enter subjective response/comments/complaints).
Education provided on *(list detail of skilled training)*.

Oral Motor

Pt demonstrated
(specify improved/decreased)
• strength of facial muscles • ROM of facial muscles • tone of facial muscles • strength of lingual muscles • ROM of lingual muscles • lingual speed of movement • accuracy and control of lingual movement • ROM/coordination of tongue • ROM/coordination of back of tongue • strength of labial muscles • ROM of labial muscles • labial speed of movement • accuracy and control of lingual movement • lip closure/labial seal • accuracy and control of bolus propulsion • speed of movement of bolus propulsion • accuracy and control of bolus transfer • speed of movement of bolus transfer

—Continued on page 3

CPT Coding and Documentation for 92526, Continued

—*Continued from page 2*

- *(specify percent)* of the time
- with *(specify percent)* accuracy
- by *(specify percent)*

- using pacing techniques
- using metronome
- using ample breath support
- using decreased speed of speech production
- using over exaggeration of speech production

- to increase vocal fold closure
- to increase airway protection
- to decrease stasis/residue in oral cavity
- to decrease stasis/residue in pharynx
- to strengthen base of tongue
- to increase base of tongue movement
- to increase laryngeal elevation
- to clear food/liquid from oral cavity
- to clear food/liquid from pharynx
- to increase pharyngeal wall contraction
- to improve timing of swallow reflux
- to increase bolus control
- to increase bolus formation

(Enter subjective response/comments/complaints).

Education provided on *(list detail of skilled training)*.

Swallow

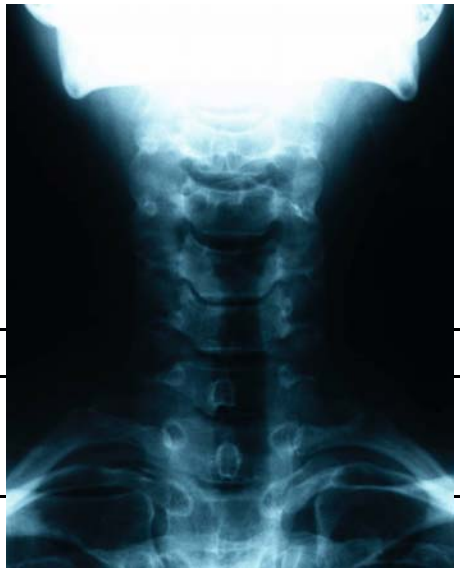
Pt performed

- Masako swallow
- supraglottic swallow
- super supraglottic swallow
- tongue base retraction exercise
- Mendelsohn maneuver
- Shaker maneuver
- effortful swallow
- hard swallow
- double swallow
- dry swallow

(specify in # of minutes/# of times)

- *(specify percent)* of the time
- with *(specify percent)* accuracy
- by *(specify percent)*

- to increase vocal fold closure
- to increase airway protection
- to decrease stasis/residue in oral cavity



—*Continued on page 4*

CPT Coding and Documentation for 92526, Continued

—*Continued from page 3*

- to decrease stasis/residue in pharynx
- to strengthen base of tongue
- to increase base of tongue movement
- to increase laryngeal elevation
- to clear food/liquid from oral cavity
- to clear food/liquid from pharynx
- to increase pharyngeal wall contraction
- to improve timing of swallow reflux
- to increase bolus control
- to increase bolus formation

(Enter subjective response/comments/complaints).

Education provided on *(list detail of skilled training)*.

Oral Phase According to Oral Symptoms

Pt demonstrated

- decreased drooling by increasing sensation, lip closure, lingual control and frequency of swallow
- decreased food residue in mouth by increasing sensation, lingual strength and coordination
- decreased pocketing of food in mouth by increasing sensation and facial strength
- improved bolus formation by increasing ROM/coordination of tongue
- improved rate of bolus transfer by increasing vertical ROM of tongue, lingual coordination and strength
- improved mastication by increasing lateral ROM, sensation and coordination of tongue
- improved lingual/velar closure by increasing ROM/coordination/back of tongue, strength of palate
- decreased premature spillage into pharynx by increasing oral sensation and tongue/palate contact
- decreased residue on palate with thicker foods by increasing lingual strength
- increased initiation of swallow reflex by increasing tongue coordination/ROM

using

- hand pressure *(specify area)*
- food placement on unaffected side
- alternate liquid/solid consistencies
- alternate lemon Italian ice/solids
- manual buccal pressure
- manual buccal sweep
- tongue sweep
- finger sweep
- tongue blade sweep
- manual massage
- gustatory thermal stimulation

- *(specify percent)* of the time
- with *(specify percent)* accuracy
- by *(specify percent)*

to

- establish a safe, efficient swallow to meet patient's nutritional and hydration needs
- establish a safe, efficient swallow to meet patient's nutritional and hydration needs /s risk for aspiration
- sustain or gain weight and maintain adequate hydration

—*Continued on page 5*

CPT Coding and Documentation for 92526, Continued

—*Continued from page 4*

- increase quality of life
- prevent development of fevers
- prevent skin breakdown
- adequately hydrate
- prevent complications as related to poor nutritional status

(Enter subjective response/comments/complaints).

Education provided on *(list detail of skilled training)*.

Pt demonstrated

- increased sensation, lip closure, lingual control and frequency of swallow to decrease drooling
- increased sensation, lingual strength and coordination to decrease food residue in mouth
- increased sensation and facial strength to decrease pocketing of food
- increased ROM/coordination of tongue to improve bolus formation
- increased vertical ROM of tongue, lingual coordination and strength to improve rate of bolus transfer
- increased lateral ROM, sensation and coordination of tongue to improve mastication
- increased ROM/coordination of back of tongue/strengthen palate to improve lingual/velar closure
- increased oral sensation and tongue/palate contact to decrease premature spillage into the pharynx
- increased lingual strength to decrease residue on palate with thicker foods
- increased tongue coordination/ROM to facilitate initiation of swallow reflex

using

- hand pressure *(specify area)*
- food placement on unaffected side
- alternate liquid/solid consistencies
- alternate lemon Italian ice/solids
- manual buccal pressure
- manual buccal sweep
- tongue sweep
- finger sweep
- tongue blade sweep
- manual massage
- gustatory thermal stimulation

This article is Part I of II of CPT Coding 92526. issue 7 will feature the Pharyngeal Phase and Esophageal Phase.

- *(specify percent)* of the time
- with *(specify percent)* accuracy
- by *(specify percent)*

to

- establish a safe, efficient swallow to meet patient's nutritional and hydration needs
- establish a safe, efficient swallow to meet patient's nutritional and hydration needs /s risk for aspiration
- sustain or gain weight and maintain adequate hydration
- increase quality of life
- prevent development of fevers
- prevent skin breakdown
- adequately hydrate
- prevent complications as related to poor nutritional status

(Enter subjective response/comments/complaints).

Education provided on *(list detail of skilled training)*.

Group Activities for Arthritis

Participants should include those with a diagnosis of osteoarthritis (OA) or degenerative joint disease (DJD), rheumatoid arthritis (RA), fibromyalgia or joint impairments which limit ADL performance and/or various functional mobility activities.

Purpose of Group Treatment for Arthritis

- Educate about arthritis including factors that impact arthritis and tips for managing arthritis
- Increase grip/pinch strength, range of motion and activity tolerance to perform ADLs
- Improve ability to perform self monitored non-resistive exercise routine
- Reduce pain and prevent further joint deformities through education and application of joint protection strategies, stress management techniques and exercises
- Educate on energy conservation and work simplification techniques for ADLs
- Educate on compensatory techniques and the use of adaptive equipment

Contraindications

- In the presence of arthritis flare-up stage and/or pain it is important to eliminate resistive exercises to affected joints

Suggested Group Activities

- Aquatic exercise programs
- Self range-of-motion exercises (e.g., balloon volleyball, parachute activities)
- Flexibility and strengthening exercises

- Stress reduction & relaxation exercises
- Education in energy conservation/work simplification techniques
- Modified Yoga
- Tai Chi
- Isometric strengthening
- Pain management education
- Joint protection education
- Adaptive equipment training/instruction
- Environmental modification education
- ADL training utilizing compensatory techniques

Background Information:

Arthritis: Arthritis refers to a disease of the joints, resulting in pain, swelling, stiffness or loss of joint function. This is no cure for most types, but there are steps to minimize the symptoms which impact your life. Two types of arthritis, Osteoarthritis and Rheumatoid arthritis. Other types of arthritis which usually effect older adults include gout and pseudogout, spondyloarthropathies, polymyalgia rheumatica, giant cell arteritis, system lupus erythematosus, infectious arthritis to name a few.

Osteoarthritis (OA): A degenerative wearing and deteriorating of the cartilage in joints, develops slowly, could be enhanced by genetics, severe trauma, or improper use of a joint.

Rheumatoid Arthritis (RA): 75% occurs in women, considered an autoimmune disease. The immune system attacks joint linings (synovial membranes) which lubricate (protects) joints. This causes inflammation which if persistent causes chemicals and enzymes to deteriorate cartilage and bone.

Fibromyalgia: A chronic, widespread muscle pain which encompasses 11 of the 18 "tender spots" in the body. Occurs in 80—90% in women. Possible causes are attributed to nerve damage.

Group Treatment Guidelines

For Medicare A: Group consists of treatment by one therapist to 2 – 4 patients who are performing the **same** or very similar activity at the same time. The ratio of patients to therapist should not exceed 4:1. Regarding billing:

- Total time patient actively participates in group should be billed, as long as time is a minimum of 15 minutes
- Total group minutes must not exceed 25% of each therapy discipline's total weekly/assessment treatment time
- Group cannot be supervised by a rehab aide

For Medicare B: Group consists of simultaneous treatment by one therapist to 2 - 4 patients who may or may not be performing the same activities. The Therapist providing group therapy services must be in constant attendance, but one-on-one patient contact is not required.

A therapist may choose to work simultaneously with 3 Medicare B patients in a 45-minute period, providing intermittent one-on-one contact. The therapist may only bill each patient the number of units of a CPT code according to the time spent providing one-on-one intervention.

CMS has provided the following group scenarios for Medicare B:

- ***Example A:*** Two patients are treated over the same 30 minute period; however, 1:1 time occurs with each patient. The therapist should bill the appropriate individual CPT code per patient according to the amount of individual therapy time spent.
- ***Example B:*** Two patients are treated simultaneously over the same 30 min period however, therapist is dividing time between both patients providing brief intermittent personal contact . The therapist should bill two group CPT (e.g., 97150* or 92508*) codes per patient.
- ***Example C:*** Patient A receives 15 mins of 1:1 treatment time (8-8:15 am). Patient B comes in, and receives 15 mins of treatment time. Patient A leaves at 8:30. Patient B remains in 1:1

Documentation Guidelines

If services are provided to a patient as a member of a group, the criteria for coverage requirements for PT, OT and ST must be met. This includes the following:

- Prescription by a physician, based on an active treatment plan (e.g., PT 5x/wk x 4wks for therapeutic activities, gait training and neuromuscular re-education in either group or individual setting)
- Performance by or under the general supervision of a qualified therapist
- Service must be tailored to address each patient's specific skilled rehabilitation needs

Follow specific fiscal intermediary (FI) and/or carrier requirements, which may include the need for documentation supporting:

a) Treatment goal addressed in the group
b) Specific treatment techniques utilized during group
c) Group frequency and duration
d) Number of persons in the group
e) Total time spent in a group setting

Billing Guidelines CPT Codes:

PT/OT Group 97150

ST Group 92508

- Appropriate modifiers and clinical documentation to justify group treatment
- Each resident participating in the group must have an individualized treatment plan for group treatment including interventions, short and long term goals

ICD-10 & HIPAA 5010 Compliance In The Cloud

By: Ken Congdon, Editor-in-Chief, Healthcare Technology Online

While much of the national news coverage has focused on EHR (electronic health record) adoption/ meaningful use and healthcare reform, perhaps the most significant IT challenge for healthcare providers over the next few years will be HIPAA (The Health Insurance Portability and Accountability Act) 5010 and ICD-10 (International Classification of Diseases, 10th edition) compliance. HIPAA 5010 is a new set of standards that regulate the electronic transmission of specific healthcare transactions including eligibility, claim status, referrals, claims, and remittances. Version 5010 carries at least 1331 modifications spanning all 9 standard electronic transactions and includes improvements in structural, technical, and data content (including improved eligibility responses and better search options). It also is more specific in requiring the data that is needed, collected, and transmitted in a transaction (such as tightened and clear situational rules).

ICD-10, on the other hand, is a coding of diseases, symptoms, abnormal findings, social circumstances, and causes of injury as classified by the World Health Organization. ICD-10 calls for a complete replacement of the ICD-9 code sets used to report medical diagnoses and procedures. ICD-10 does more than just replace the old ICD-9 code set, it also adds five times as many codes to the classification structure.

Both HIPAA 5010 and ICD-10 affect all segments of the healthcare industry including providers, clearinghouses, health plans, and government agencies. However, providers are ultimately responsible for compliancy and, in most cases, this compliancy will require significant upgrades to a healthcare facility's IT systems. Because of the IT investment necessary and the short compliance time windows (U.S. healthcare organizations must comply with HIPAA 5010 by January 1, 2012 and ICD-10 by October 1, 2013), many providers are beginning to consider cloud computing or Software-as-a-Service (SaaS) offerings as a viable option to achieve compliance with these mandates quickly and cost-effectively.

SaaS SECURITY CONCERNS GIVE WAY TO COMPLIANCE PROMISE

While cloud computing has caught on in other facets of healthcare IT (see related article, Cloud Storage Solves The Medical Imaging Data Problem), SaaS offerings haven't historically been embraced for HIPAA and patient coding applications due to the privacy and security concerns that have surrounded the platform. In other words, SaaS applications often carried the stigma of being "risky" because patient data is stored in an off-site facility maintained by a third party rather than controlled internally via an on-premises system. However, as more healthcare facilities have documented successes using SaaS for numerous applications, from workforce optimization to EHR archiving and management, these security concerns have begun to wane.

With security issues becoming less of a sticking point for SaaS adoption in healthcare, IT departments are beginning to realize the significant impact cloud applications can have on HIPAA 5010 and ICD-10 compliance. For example, since SaaS offerings aren't installed internally, they require little to no IT support. When you subscribe to a SaaS service, you don't have to dedicate your in-house IT staff to implement the solution or hire a systems integrator to install and integrate the product with your existing applications.

—Continued on page 12

Demand Denials (Condition Code 20)

A demand denial allows a beneficiary to request Medicare to review services that:

- their Home Health Aide (HHA) advised was not medically reasonable and necessary; or
- failed to meet the homebound or intermittent requirements, and therefore, would not be reimbursed if billed

NOTE:
If the HHABN was provided because the services do not meet the Medicare covered benefit definition (i.e., routine foot care) or are custodial in nature (housekeeping or home health aide services) and the beneficiary has authorized billing Medicare, the HHA should submit a no-pay bill using condition code 21.

The HHA must inform the beneficiary of their decision with a Home Health Advance Beneficiary Notice (HHABN), which also must be signed by the beneficiary or appropriate representative before any services are provided. The HHABN provides the beneficiary with the option to have a demand denial (condition code 20) submitted to Medicare for review. The HHA must comply with the beneficiary's request to submit a demand bill (condition code 20).

Demand denials must be submitted promptly once the last billable service is provided and the physician's signature has been obtained for all orders. Beneficiaries may pay out of pocket or third party payers may cover the services in question. All demand denials will be subject to medical review through the additional development request (ADR) process.

If medical review determines some or all of the disputed services are covered, the HHA must refund any previously collected funds.

If medical review upholds the HHA's decision that the services were not coverable, the HHA keeps the funds collected from the beneficiary. However, if the Regional Home Health Intermediary (RHHI) determines the HHABN notification was not properly executed, or some other factor changed liability for payment of the disputed services to the HHA, the HHA must refund any funds collected.

Billing Requirements

In demand denial situations, a request for anticipated payment (RAP) is required to be billed as usual; do not submit the RAP with condition code 20. The condition code of 20 would be submitted on the final claim. The RAP will process and pay the appropriate percentage payment and the episode will be posted to the beneficiary eligibility record (ELGA/ELGH). Demand denial (condition code 20) information is submitted on HH PPS claims with a TOB (type of bill) 329 and includes all the required information including all visit-specific detail for the entire HH PPS episode. Please note that TOB 3X0 is no longer valid for demand bills where condition code 20 is used. The following information must also be provided on a demand bill:

- Condition code 20
- Charges for services in dispute shown as covered and non-covered
- Remarks indicating the reason for the demand denial (condition code 20)
- If there are covered and non-covered services during the same episode, bill all services on one claim

(https://www.cahabagba.com/rhhi/claims/home_health/demand_denials.htm)

Contributors to this issue include: Lisa Jenkins, MPT, BBA, CHC, PT Consultant

New AAP Guidelines Aim to Boost Immunization Rates

By Chris Emery, Contributing Writer, MedPage Today
Published: June 01, 2010
Reviewed by Zalman S. Agus, MD; Emeritus Professor
University of Pennsylvania School of Medicine and
Dorothy Caputo, MA, RN, BC-ADM, CDE, Nurse Planner

The American Academy of Pediatrics (AAP) has released a wide-ranging set of recommendations aimed at increasing immunization rates among children and adolescents in the face of vaccine shortages, rising costs, and a vocal antivaccine movement.

The policy statement, published online in *Pediatrics*, calls for pediatricians to ensure that every child receives all of the recommended childhood immunizations on time unless there are valid contraindications.

The statement also calls for doctors, pediatric organizations, and government agencies to do a better job communicating to parents the safety and efficacy of vaccines.

Action Points

- Note that the American Academy of Pediatrics (AAP) has released new guidelines to increase immunization among U.S. children, adolescents, and young adults.
- Note that the AAP calls for doctors and child health professionals to carefully explain to parents the benefits and risks of childhood vaccines.

""A vast number of new challenges that threaten continued success toward the goal of universal immunization coverage have emerged," lead authors Lawrence D. Hammer, MD, of Lucile Packard Children's Hospital at Stanford University, and Herschel R. Lessin, MD, of the Children's Medical Group in Poughkeepsie, N.Y., and colleagues wrote.

Among the hurdles to universal immunization, the AAP cited an increase in new vaccines and vaccine combinations, a six-fold increase in costs coupled with inadequate reimbursement, sporadic vaccine shortages, and a continuing campaign by the anti-vaccine movement to link childhood immunizations with autism despite a lack of any scientific evidence to support this position.

The new policy statement revises 2003 guidelines for increasing immunization coverage and is based on new data from the 2007 National Immunization Survey.

The 2007 survey found that 90% of U.S. children 19 to 35 months of age had received recommended doses of the following vaccines: inactivated poliovirus (IPV), measles mumps-rubella (MMR), varicella zoster virus (VZV), hepatitis B virus (HBV) and *Haemophilus influenzae* type b (Hib).

Also, a goal of immunizing 80% of adolescents for diphtheria and tetanus and acellular pertussis (DTaP) had been met, with 84.5% of adolescents having received the recommended four doses of the vaccine by 35 months of age.

Despite these encouraging numbers, the authors wrote, there are serious barriers to achieving 100% immunization of American children. To address the problem of occasional vaccine shortages, the AAP statement encourages pediatricians and child health professionals to advocate for reform in the distribution and payment systems for various stages of vaccine production and immunization processes.

The AAP also urges members to push for a public-private partnership in the manufacture and distribution of vaccines, so that vaccine purchasers can plan more effectively and reduce their financial risk.

The statement writers noted that since 1995 the cost of fully immunizing a child through age 18 has risen to $900 for boys and more than $1,200 for girls, largely because of the introduction of new vaccines such as the one against varicella zoster virus, which causes chicken pox.

—Continued on page 11

New AAP Guidelines Aim to Boost Immunization Rates, Continued

—Continued from page 10

To address the high cost of some vaccines, the AAPrecommends that insurance companies and other payers cover the cost of immunizations by removing vaccine-related copays and deductibles and removing upfront costs that may prevent parents from having their children immunized. (HBV) and *Haemophilus influenzae* type b (Hib).

It also recommends that pediatricians help identify alternative locations, such as childcare centers and schools, where children can receive immunizations.

The policy statement writers also expressed concerns about the continuing growth of the anti-vaccine movement that "uses the Internet as well as standard media outlets to advance a position, wholly unsupported by any scientific evidence, linking vaccines with various childhood conditions, particularly autism."

New and existing organizations and Web sites that "portray themselves as official resources for credible information on vaccines continue to appear on the Internet," promoting "flawed or biased information" that fuels public concern about the safety of childhood immunizations, the authors noted.

As a result, pediatricians are seeing increasing numbers of parents demanding alternate immunization schedules or completely refusing vaccinations altogether and must spend "large amounts of time convincing frightened parents to follow published evidence-based recommendations," they wrote.

The AAP called on the Centers for Disease Control and Prevention, other agencies, and physicians' and professional organizations to mount a vigorous public relations campaign to better inform the public about childhood vaccinations and to counter the "influence of misinformation spread by celebrities and others who have participated in the anti-vaccination movement."

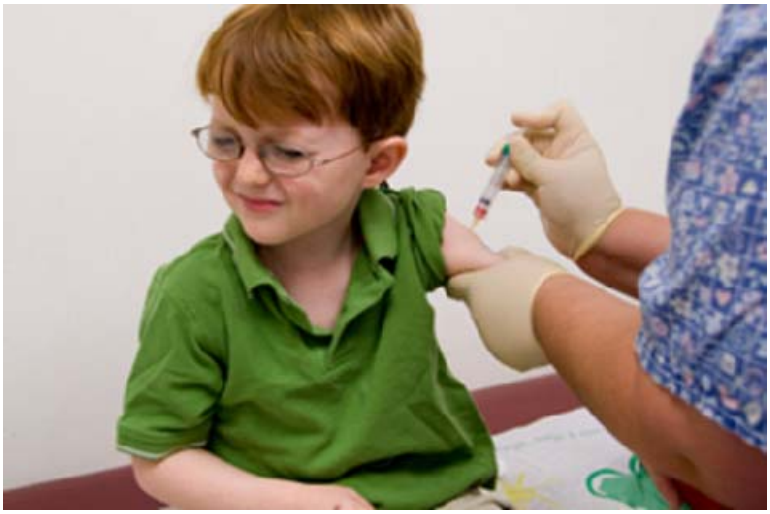
The new policy statement urges individual doctors and other child health professionals to assiduously educate parents about the risks and benefits of immunizations, and to document cases in which parents have refused immunizations for their children.

"Social marketing techniques should also be explored as a promising strategy for promoting acceptance of immunizations among members of the general public who remain hesitant or resistant to vaccinate their children," the authors wrote.

The authors reported no outside sources of funding or financial conflicts of interest.

Primary source: Pediatrics
Source reference: Hammer L, Lessin H "Policy statement -- Increasing immunization coverage" *Pediatrics* 2010; DOI: 10.1542/peds.2010-0743

http://www.medpagetoday.com/Pediatrics/Vaccines/20413



ICD-10 & HIPAA 5010 Compliance In The Cloud, Continued

—*Continued from page 8*

This enables a SaaS application to be deployed quickly. In fact, depending on how tightly the SaaS application needs to integrate with existing systems, a cloud application can be implemented and operational in a matter of days or minutes as opposed to weeks or months. Furthermore, all upgrades to the software are handled by the third party provider. This can be extremely attractive in the case of ICD-10 compliance. For example, the U.S. healthcare system is more than a decade behind the rest of the world when it comes to adopting ICD-10 and the alpha version of ICD-11 is already set to be released later this year. With ICD-11 looming, many healthcare providers aren't too keen on overhauling systems to comply with ICD mandates twice over the period of just a few years. With SaaS, healthcare providers can let the third party provider worry about the system upgrades future ICD iterations will require.

Vendors are already beginning to tap into the demand for SaaS offerings for HIPAA 5010 and ICD-10 compliance. For example, in mid-March, 3M Health Information Systems and Trizetto Group announced that 3M's ICD-10 Code Translation Tool will be embedded into TriZetto Advantage 10 Services SaaS application. Precyse Solutions has also announced plans to make its line of coding tools and NLP (natural language processing) technologies available via SaaS. As the deadlines for HIPAA 5010 and ICD-10 compliance approach, you can likely expect many more cloud-based compliance offerings for both providers and payers to emerge in the coming months.

(http://www.healthcaretechnologyonline.com/article.mvc/ICD-10-HIPAA-5010-Compliance-In-The-Cloud-0001?VNETCOOKIE=NO)

What's Coming Next

Pediatrics:
Study Finds Kids' Diet Tied to Asthma Risk

CPT Coding/Documentation - 92526:
Dysphagia, Part II

CMS:
The Department of Health and Human Services (HHS) Outlines Regulations for the Use and Dissemination of Individual Health Care Information

Denials:
7 Steps To NPI For HIPAA-Compliant Electronic Medical Billing Software And Service

Group Activities:
Aural Rehabilitation

Documentation Tips:
Functional Mobility