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Emergency Medicine and Hospitalist Webinar Library Subscriptions Services

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BSA Healthcare offers web-based access to recorded versions of its popular coding and reimbursement webinars. Benefits of web-based training include:

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An annual subscription to one of our four existing webinar libraries provides unlimited access to all of the recorded webinars in that library. Fees for each subscription are as follows:

- Subscription #1: Emergency Medicine Provider Documentation Webinar Library - $2,000 annually
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Subscription #1: Emergency Medicine Provider Documentation Webinar Library

Title: Emergency Medicine Provider Documentation Straight Talk: Critical Concepts Every Provider Should Know

Presented by: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 50:54

Given the inherent environment of the average ER, it is easy to overlook the significance of proper completion of the medical record. Poor documentation precludes the ability to code a specific service, and can result in down coding a visit to a lesser code in order to ensure compliance with documentation and coding rules and regulations.

This webinar will give your providers specialty-specific information and tools they can use every day to accurately and completely report emergency medical services.

Topics include:

- Documentation concepts and financial considerations.
- Key chart elements – History, Exam, and Medical Decision Making.
- Medical Necessity.

Title: Critical Care for the Emergency Medicine Provider

Presented by: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 61:23

The key to collecting maximum reimbursement for Critical Care services is in first recognizing Critical Care-type cases, and then documenting them appropriately. This webinar addresses the nuances that providers must consider when documenting these high-severity cases.

Topics include:

- Critical Care definitions and regulations.
- Trauma and medical example scenarios.
- What doesn't qualify as Critical Care?
- Vital Signs and lab values that often indicate Critical Care-type cases.
- Therapeutic interventions commonly ordered for Critical Care patients.
- Procedures common to Critical Care.
- Medications commonly administered to Critical Care patients.
- Financial considerations.

Title: Emergency Medicine Procedures: Documentation Concepts Every Provider Should Know

Presented by: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 46:00

Variances between E/M and procedure code utilization ranging from 14% to 38% are commonly seen by auditors, and are indicative of a need for additional training in proper recognition of these reimbursable services. Hosted by Dr. John Stimler, this webinar will teach providers how to properly document procedures that are performed in an emergency department setting.

Topics include:

- The most common ED procedures.
- Areas of the patient record where procedures are most often documented.
- Proper procedure documentation.

Subscription #2: Emergency Medicine Revenue Cycle and Reimbursement Training Webinar Library for New Emergency Medicine Providers and Residents

Title: Basic Billing Processes and Terminology

Presented by: Jeffrey Bettinger, MD, FACEP

Medical billing and coding are complex vocations that require extensive knowledge of the healthcare system, accounting, and a vast suite of medical code sets. This webinar uses simple language to familiarize new emergency medicine doctors and residents with emergency medicine billing processes and terminology used by medical billing specialists and their peers.

Topics include

- The encounter tracking process.
- Types of billing arrangements.
- Coding.
- Patient account Generation.
- Credentialing.
- Accounts Receivable Management.
- Payment posting and accuracy.
- Billing reports.
- Bundling.
- Conversion factor.
- Bad debt.

Title: Emergency Medicine Documentation Done Right – Evaluation and Management Documentation Concepts

Presented by: John Stimler, DO, CPC, CHC, FACEP

Given the inherent environment of the average ER, it is easy for new emergency medicine doctors and residents to overlook the significance of proper completion of the medical record. Poor documentation precludes the ability to code a specific service, and can result in downcoding a visit to a lesser code in order to ensure compliance with documentation and coding rules and regulations.

This webinar will provide emergency medicine doctors and residents with specialty-specific information and tools they can use every day to accurately and completely report emergency medical services.

Topics include:

- The financial impact of poor documentation.
- Key chart elements – History, Exam, and Medical Decision Making.
- Medical Necessity.

Title: Emergency Medicine Documentation Done Right – Critical Care

Presented by: John Stimler, DO, CPC, CHC, FACEP

The key to collecting maximum reimbursement for Critical Care services is in first recognizing Critical Care-type cases, and then documenting them appropriately. This webinar instructs participants on Critical Care requirements and indicators that can suggest Critical Care-type cases, ensuring that new emergency medicine doctors and residents have the tools they need to successfully document these high-risk cases.

Topics include:

- Critical Care definitions and regulations.
- Trauma and medical example scenarios.
- What doesn't qualify as Critical Care?
- Vital Signs and lab values that often indicate Critical Care-type cases.
- Therapeutic interventions commonly ordered for Critical Care patients.
- Procedures common to Critical Care.
- Medications commonly administered to Critical Care patients.
- Financial considerations.

Title: Emergency Medicine Documentation Done Right – Procedures

Presented by: John Stimler, DO, CPC, CHC, FACEP

Proper documentation of procedures is critical to ensuring maximum reimbursement for these services. Hosted by Dr. John Stimler, this webinar will teach new emergency medicine doctors and residents how to properly document procedures that are performed in an emergency department setting.

Topics include:

- The most common ED procedures.
- Areas of the patient record where procedures are most often documented.
- Proper procedure documentation.

Title: Emergency Medicine Documentation Done Right – Diagnoses

Presented by: John Stimler, DO, CPC, CHC, FACEP

More than ever, governmental and non-governmental payers are finding ways to avoid or reduce payments for medically necessary services. Often, auditors cite principal diagnostic code choice as the primary reason for downcoding or denying a claim. This webinar will ensure that new emergency medicine doctors and residents understand the critical nature of proper documentation of a working list of differential diagnoses and a principal diagnosis as the forerunners of a properly coded and paid claim.

Topics include:

- The importance of diagnostic code choice.
- Acute vs. chronic conditions.
- Traumatic vs. medical diagnoses.
- Core features of ICD-10.
- Chief compliant and signs and symptoms.
- Choice of principal diagnosis.
- Documentation considerations.

Title: Emergency Medicine Documentation Done Right – Advanced Reimbursement Concepts

Presented by: John Stimler, DO, CPC, CHC, FACEP

This webinar will provide emergency medicine doctors and residents with a high-level overview of advanced reimbursement concepts as they apply to the specialty of emergency medicine.

Topics include:

- Diagnostic code documentation considerations.
- Documentation requirements for Evaluation and Management Codes 99281 – 99285.
- Relative Value Units (RVUs).
- E/M distribution considerations.
- The financial impact of poor documentation.
- Documentation of high-severity cases.
- Medical Decision Making (MDM).
- Medical necessity.

Subscription #3: Emergency Medicine Coding, Billing, and Practice Management Webinar Library

This program has the prior approval of AAPC for 53 continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.

Coding for COVID-19 – This webinar is not eligible for CEUs as the total run time does not meet the 30 minute minimum requirement.

Presented by: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 13:52

The COVID-19 pandemic is putting strain on the healthcare system, but accurately capturing data and documenting cases of the novel coronavirus is critical for emergency medicine providers. COVID-19 coding and billing allows providers to track the numbers of patients seen with COVID-19, and to get paid for treating the patients presenting with symptoms of the disease. This webinar addresses proper utilization of code U07.1, and assignment of the right codes for any associated manifestations, and signs and symptoms.

COVID-19 and Telemedicine in the ER – This webinar is not eligible for CEUs as the total run time does not meet the 30 minute minimum requirement.

Presented by: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 14:07

During the COVID-19 public health emergency, telehealth offers medical practices the ability to continue to provide care to patients with or without COVID-19. In order to mitigate exposure of patients who are sick or at-risk due to other conditions, as well as protect the healthcare workers and community, practices are strongly encouraged to use telehealth whenever possible and to consider establishing protocols and procedures for use by practice staff and clinicians. Now in a full state of emergency, many Medicare restrictions related to telehealth have been lifted. This webinar addresses telehealth visit and medical

screening exam rules, code sets, and documentation requirements for emergency medicine and hospitalist providers.

Critical Care - An Update: Are You Over or Underutilizing Critical Care Codes? – AAPC Approved for 1.5 Core A CEUs or CEDC credits

Presented by: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:30:25

The key to collecting adequate reimbursement for Critical Care is in first recognizing Critical Care-type cases, and then documenting and coding them appropriately. This two-hour webinar will focus on updates to our original Critical Care webinar, and will address the nuances that providers and coders must consider when documenting and coding for these high-severity cases.

Topics include:

- Critical Care Definitions and Regulations.
- Trauma and Medical Example Scenarios.
- What Doesn't Qualify as Critical Care?
- Documentation Pearls that reinforce a Critical Care-type case.
- Aberrant Vital Signs that may indicate a Critical Care-type case.
- Therapeutic Interventions and medication commonly ordered for Critical Care patients
- Procedures common to Critical Care.
- Aberrant lab values that may indicate a Critical Care-type case.

Title: Critical Care: What Qualifies and What Doesn't? – AAPC Approved for 1.0 CEUs, CEDC or CEMC credit

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 40:48

Critical care billing is justified if a patient has a medical condition that "impairs one or more vital organ systems" and "there is a high probability of imminent or life-threatening deterioration in the patient's condition" provided a physician has provided "frequent personal assessment and manipulation" of the patient's condition. While some conditions that qualify for critical care billing are more obvious, emergency physicians often care for patients with many other conditions that may also quality for critical care billing, rendering distinction between critical care and non-critical care type cases difficult. This 40-minutes webinar will focus on patient presentations and specific case types that - assuming proper documentation as a baseline - qualify and don't qualify for application of Critical Care code 99291.

Patient presentations that are addressed include:

- Abdominal Pain.
- Chest Pain.
- Shortness of Breath.
- Multiple Trauma.
- Changing Mental Status.
- GI Bleed – Rectal Bleeding or Hematemesis.

Title: Critical Care in Emergency Medicine - A Review of Common Questions from Coding Educators, QA Coordinators, and Compliance Professionals – AAPC Approved for 1 Core A CEU, CEDC, or CEMC Credit

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:22:18

This webinar will address questions that are commonly posed to us by coding educators, QA coordinators, and compliance professionals about high-complexity, high-severity, Critical Care-type cases.

Topics include:

- Interventions.
- Objective criteria that qualifies certain case types for Critical Care including:
  - Small bowel obstruction.
  - Overdose.
  - Anemia.
  - GI or rectal bleed.
  - Thrombotic CVA.
  - Respiratory distress.
  - Seizures.
  - Hypotension/Hypertension.
  - Hyperkalemia.
  - Angina and chest pain.
  - Acute renal failure.
  - Sepsis.
  - Altered mental status.
  - Hip and spinal fractures.
  - Pancreatitis.
  - Abdominal pain.
- The phrase "preventing further deterioration." What does this phrase mean, and how does it support Critical Care?

Title: Pediatric Critical Care – AAPC Approved for 1.0 Core A CEUs, CEDC or CPEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 47:19

Coding pediatric E/M levels including Critical Care codes 99291 and 99292 is governed by the American Medical Association's (AMA) CPT® guidelines, as well as the Centers for Medicare & Medicaid Services' (CMS) 1995 Documentation Guidelines for Evaluation and Management Services. While these guidelines ensure ED coding is consistent across our nation's EDs, because pediatric ED visits and treatments are often unique and not always well represented by documentation guidelines, particularly regarding MDM, pediatric ED visits are sometimes undervalued.

The key to collecting adequate reimbursement for pediatric Critical Care services is in first recognizing Critical Care-type cases, and then documenting and coding them appropriately. This webinar focuses on pediatric ED patient presentations and specific case types that - assuming proper documentation as a baseline - qualify for application of Critical Care code 99291.

Topics that are addressed include:

- What qualifies for Critical Care and what doesn't?
- Pediatric Critical Care Benchmarks
- Pediatric Critical Care Vital Signs, Lab Results, and Medications
- Top 25 Critical Care Diagnoses in 0 to 6 year-old patients
- Top 25 Critical Care Diagnoses in 7 to 17 year-old patients.

Title: Pediatric Emergency Medicine Evaluation and Management Code Choice – AAPC Approved for 1.5 Core A CEUs, CEDC or CPEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:38:36

Coding the five emergency department E/M levels (99281-99285) is governed by the American Medical Association's (AMA) CPT® guidelines, as well as the Centers for Medicare & Medicaid Services' (CMS) 1995 Documentation Guidelines for Evaluation and Management Services. While these guidelines ensure ED coding is consistent across our nation's EDs, because pediatric ED visits and treatments are often unique and not always well represented by documentation guidelines, particularly regarding MDM, pediatric ED visits are sometimes undervalued.

Proper pediatric ED coding requires an understanding of the types of cases pediatric EDs see on a regular basis, as well as the challenges ED providers face in treating young patients. This webinar will educate coders on the nuances of coding for pediatric emergency medicine encounters.

Topics covered in this webinar include:

- How Pediatric Work-ups, Treatments, and Dispositions Differ from Adult Emergency Medicine Encounters
- Adult vs Pediatric Emergency Medicine E/M Distributions
- E/M Code Choice Review
- Common Chief Complaints
- Low Moderate Risk and Moderate Complexity Cases
- High Moderate Risk and High Complexity Cases
- High Risk and High Complexity Cases.

Title: Emergency Medicine CPT® Code 99285 – A Comprehensive Review – AAPC Approved for 1.5 Core A CEUs or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:14:38

This webinar will address the factors that help define high severity emergency medicine cases that pose an immediate threat to life or physiologic (bodily) function. Dr. Stimler will examine both admitted and discharged patient presentations that fit within the high severity description. He will also focus on objective criteria in order to help coders understand the significance of various ancillary studies and therapeutic interventions, and the significance they play in determining case severity. A review of Tables A, B, and C to determine MDM level combined with the requirements for history and exam documentation will be covered. Clinical examples for medical and traumatic complaints will also be covered.

Topics include:

- Level 5 CPT® definitions and examples.
- Level 5 History and Exam documentation requirements.
- MDM and Level 5.
- Clinical considerations and case examples.
- Comparison of Level 5 objective criteria to Level 4 and Critical Care criteria.
- Common misconceptions and "gray areas."
- Payer audit focus on Level 5.

Title: Emergency Medicine CPT Codes 99283 and 99284 – Distinguishing the Difference Between the Two – AAPC Approved for 1.5 Core A CEUs or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:21:32

Combined, Level Three and Level Four Evaluation and Management (E/M) codes are the most commonly reported codes in emergency medicine. Without objective criteria that helps define the difference between the two, proper assignment of these codes is difficult given the subjective nature of coding and its many "gray areas." This webinar will address the subtle and not so subtle differences that distinguish Level Three and Level Four services.

Topics include:

- Level Three and Level Four CPT definitions and documentation requirements.
- Level Three clinical considerations, criteria, and case examples.
- Level Four clinical considerations, criteria, and case examples.
- MDM's influence on Levels Three and Four.
- Common misconceptions and "gray areas."

Title: Emergency Medicine Procedures: Recognizing Procedures in the ED Chart, Clinical Examples & Descriptions – AAPC Approved for 1.5 Core A CEUs, or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:23:05

Procedures are often overlooked by emergency medicine coders because they are often buried in areas of ED records that are not obvious on cursory review. Variances between E/M and procedure code utilization ranging from 14% to 38% are commonly seen by auditors, and are indicative of a need for additional training in proper recognition of these reimbursable services. Hosted by Dr. John Stimler, Managing Member of BSA Healthcare, this webinar will teach coders, compliance personnel, reimbursement directors, and providers how to recognize and properly code procedures performed in an emergency department setting.

Topics include:

- The most common ED procedures.
- Areas of the patient record where procedures are most often documented.
- Proper procedure documentation.
- Proper procedure code choice.
- Clinical examples and illustrations.

Title: Critical ICD-10 Concepts for the Emergency Medicine Coder – An Seven-part Webinar Series

Presenter: John Stimler, DO, CPC, CHC, FACEP

Part 1 –Total Run Time: 57:22 – AAPC Approved for 1.0 Core A CEUs and all specialties except CIRCC
Part 2 – Total Run Time: 1:02:35 – AAPC Approved for 1.0 Core A CEUs or CEDC credits
Part 3 – Total Run Time: 1:29:39 – AAPC Approved for 1.0 Core A CEUs or CEDC credits
Part 4 – Total Run Time: 1:11:47 – AAPC Approved for 1.0 Core A CEUs or CEDC credits
Part 5 – Total Run Time: 1:12:54 – AAPC Approved for 1.0 Core A CEUs or CEDC, CPCO, CPMA credits
Part 6 – Total Run Time: 1:16:56 – AAPC Approved for 1.0 Core A CEUs or CEDC credits
Part 7 – Total Run Time: 1:10:57 – AAPC Approved for 1.0 Core A CEUs or CEDC credits

Since implementation, Bettinger, Stimler & Associates has been approached by many emergency medicine groups and billing and coding companies with questions about ICD-10, including those ICD codes that are frequently being used, and whether these codes are appropriate given the uniqueness of the specialty and the specificity requirements. This two-part webinar will address the most frequently raised questions.

Topics include:

- Overall concepts.
- Selecting a first-listed or primary diagnosis.
- Inpatient vs. outpatient diagnostic coding specifics with a focus on emergency medicine coding.
- Top 50 ICD-10 codes for the specialty of emergency medicine.

Title: Fracture and Dislocation Care Coding in Emergency Medicine Update – AAPC Approved for 1.5 Core A CEUs, CEDC, CGSC, CPMA, or CSFAC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 1:02:49
This webinar will teach coders about the various nuances of proper fracture and dislocation care coding in emergency medical practice.

Topics include:

- Review of the bones and joints that influence choice of fracture and dislocation codes.
- Proper utilization of the -54 and -25 modifiers.
- How definitive and restorative care apply to emergency medicine.
- Potential coding and reimbursement conflicts with other specialties.
- The most common splint applications.
- Use of splint codes and compliance issues related to the use of pre-fabricated splints.

Title: Observation Documentation and Coding in Emergency Medicine – AAPC Approved for 1.0 Core A CEUs or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 51:24
Although many ED clinicians are providing extended care in the emergency department, the increased services for diagnostic uncertainty or therapeutic intensity are not always coded and billed. While observation codes can be used to bill for various extended care-type services, proper chart documentation is critical, and coders should be trained in proper application of observation codes.

Topics include:

- Specific observation documentation and coding requirements for Medicare versus other payers.
- Same day versus over-midnight observation codes.

Title: Ultrasound Documentation and Coding in Emergency Medicine – AAPC Approved for 1.0 Core A CEUs or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 40:52
Because the use of ultrasound has become more commonplace in the emergency department, coders must know the rules that govern proper documentation and coding of ultrasounds.

Topics include:

- Coding and billing of ultrasound interpretations in the ED.
- Documentation requirements. Is a copy of the ultrasound necessary?
- The most common ultrasound codes used for services provided by ED clinicians.
- Diagnostic code choice requirements.

Title: Use of the Medicare Audit Tool – A Two-part Webinar Series

Presented by: John Stimler, DO, CPC, CHC, FACEP
Part I Total Run Time: 1:57:43 – AAPC Approved for 1.5 Core A CEUs or CEDC credits
Part II Total Run Time: 1:56:56 – AAPC Approved for 1.5 Core A CEUs or CEDC credits

The original "Marshfield Clinic Audit Tool" and the current "Medicare Documentation Worksheet" are commonly used by emergency medicine coding organizations with the realization that these guidelines were originally developed for use by multi-specialty clinics and office-based medical practices, and not for the practice of emergency medicine. The chosen MDM level is used in conjunction with the History and Exam levels to assist coders in determining the proper Evaluation and Management code for services provided by emergency physicians. Hosted by Dr. John Stimler, Managing Member of BSA Healthcare, this webinar will teach coders, compliance personnel, reimbursement directors, and providers how to properly interpret and utilize the Medicare Audit Tool for emergency medicine E/M coding.

Topics include:

- Clarification regarding the Medicare Audit Tool Tables A, B, and C, with a focus on proper choice of emergency medicine E/M codes.
- Objective criteria for many subjective phrases found in the three tables.
- Detailed discussion surrounding the moderate level of the Risk Table as this level incorporates the biggest range of MDM.
- Case examples for E/M codes 99281 through 99285.

Title: CMS vs. CPT® E/M Coding Requirements and Payer Considerations and Admissions and Transfers Case Level Severity Review – AAPC Approved for 1.5 Core A CEUs, CEDC, and all specialties except CIRCC and CASCC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 1:43:50

CMS vs. CPT E/M Coding Requirements and Considerations

There are notable differences in the CMS and CPT documentation requirements that influence code choice depending on the payer. Understanding these differences is crucial to proper E/M code choice.

Topics include:

- CPT Documentation Guidelines and History, Exam, and MDM.
- CMS Documentation Guidelines and how they are different.
- CMS vs. CPT Guideline differences and how they impact E/M code choice 99281 - 99291 CMS vs. CPT Procedure Code differences.

The Significance of Admissions and Transfers

Admissions and transfers are common in the practice of emergency medicine. Does admission to the hospital, or transfer to another facility, usually generate a Level Five or Critical Care code choice? While

many admitted and transferred cases represent high acuity, high severity patients, there are some that are commonly coded at Level Four.

Topics include:

- Examples of high severity cases that carry an immediate threat to life or bodily function yet still generate minimal ancillary studies and minimal therapy.
- Patient complaints and objective criteria that often generate Level Five code choice.
- Examples of admitted/transferred cases that are frequently coded at Level Four.

Title: Medical Decision Making, Medical Necessity, Payer Audits – AAPC Approved for 1.0 Core A CEUs, CEDC and all specialties except CIRCC or CASCC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:09:07

This webinar teaches physicians the importance of proper documentation of History, Exam, and Medical Decision Making along with tips related to medical necessity and summary of the severity of each case. As emergency physician reimbursement rates continue to drop and governmental and non-governmental audits increase in frequency, it has become increasingly important for clinicians to better justify any treatments that are provided and work-ups that are ordered via excellent documentation that "tells the story" of a patient encounter.

Of the three key components of provider documentation - History, Exam, and Medical Decision Making (MDM) - MDM is the most critical. The MDM level initiates the E/M code level that can potentially be achieved if the History and the Exam are documented appropriately. This webinar will explain the importance of a segment of MDM: that of justifying the ordering of ancillary studies and therapeutic interventions as "medically necessary." The presentation will also assist coders in more thoroughly evaluating the many nuances of an Emergency Department Treatment Record. The financial, compliance, and medicolegal implications of provider documentation are also addressed.

Topics include:

- Definitions and components of MDM.
- MDM's impact on code choice.
- MDM and Tables A, B, and C.
- Controversial concepts in the DMO Table.
- Medical necessity for treatment orders.
- Medical necessity for ancillary study orders for labs, x-rays and special studies.
- Documentation guidelines and requirements.
- History.
- Define level of severity.
- Choice of principal diagnoses.
- Payer audits update.
- High-severity cases.

Title: Payer Audits: Defending Yourself Against the Inevitable – AAPC Approved for 1.5 Core A CEUs, CEDC, CPCO, or CPMA credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:01:24

Due to increasing pressure to improve accountability and reduce costs for federally funded medical care, the incidence of governmental audits by both Medicare and state Medicaid programs is on the rise. Careful evaluation of governmental audits is critical to identifying common patterns of audit processes, high risk chart documentation areas, exposed codes, and reimbursement practices that have been questioned by MACs.

Topics include:

- Factors that generate payer audits.
- Types of cases that auditors typically flag for review.
- The most common reasons that auditors give for downcoding cases, and recommendations for responding to each.
- Medical necessity and auditor assumptions.
- Preparing for the inevitable. What to do before you receive an audit notice.
- Managing the Medicare Appeals Process Administrative Law Judge hearing update.

Title: Emergency Medicine Coding: Your Most Commonly Asked Clinical Questions Answered – AAPC Approved for 1.5 Core A CEUs, CEDC, CPCO or CPMA credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:46:02

In his 15 years as managing member of BSA Healthcare, Dr. John Stimler compiled a list of the most common and most controversial emergency medicine clinical questions that he regularly fields from coding educators, compliance and QA personnel, and coders.

Topics include:

- Urinary Catheters: What is the difference between a Foley catheter and an in-and-out intermittent catheter?
- What is the significance of urinary retention?
- Unstable vital signs: How many do you need?
- Syncope: What is syncope and does it signify an abrupt change in neurological status?
- Fleets enema vs. digital disimpaction: Do these treatments signify varying degrees of patient severity?
- Slit lamp: Is a slit lamp always used with a fluorescein strip? Is medication administered with either?
- Bladder Scan: What is it used for? What type of patient usually receives a bladder scan and what type of patient severity does it signify?
- Cultures: When are cultures ordered and what type of conditions warrant ordering of cultures?
- Sedation: IM moderate sedation vs. IV moderate sedation
- Cardiac Workup: what types of patients require a cardiac workup, and what does it consist of? What about "other labs" and a CXR?
- STEMI vs. non-STEMI: Should they be used instead of an acute MI? What are the most important concepts here?
- High-Risk Cellulitis: What are the indicators?
- Severe Infections: Should that include pneumonias?
- Close Observation for Airway Control: What does this mean?
- Psych Cases: Level Three, Four, and Five and Critical Care psych case examples.

Title: Emergency Medicine Coding: Controversial and Commonly Asked Emergency Medicine Coding Questions and Topics – AAPC Approved for 1.5 Core A CEUs, CEMC or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:44:20

Code choice matters. As emergency physician reimbursement rates continue to drop and governmental and non-governmental audits increase in frequency, it has become increasingly important for coding organizations to prepare coding policy that addresses the most controversial emergency medicine coding topics. In his 15 years as managing member of BSA Healthcare, Dr. Stimler has compiled a list of the most controversial and commonly asked emergency medicine coding questions that he regularly fields from coding educators, compliance and QA personnel, and coders.

Topics include:

- Admissions: Level Four and Level Five admission examples.
- Multiple Special Studies.
- Oxygen: Is it a medication and why? Can you take it from the nursing notes?
- Multiple nebulizers vs. multiple nebulizer meds.
- EKG: Why does ordering an EKG start the coder at a high moderate level?
- EKG interpretation billing plus counting under Table B.
- EMS or Rescue: What is the difference between a medical and traumatic patient arriving via EMS? Does transportation mode help a provider determine a starting point for patient severity?
- Unrelated Complaints: Examples of related and unrelated complaints.
- Acuity Caveat: When can a provider invoke it and what is the significance?
- Patient Re-examination: What needs to be documented? Is a simple check box ok?
- Procedures and High Acuity Case: Do the procedures have to be done by a doctor to classify as high risk, high severity cases?
- Splinting and Strapping.
- Non-adjacent/Adjacent/Large Area: What is the difference?
- Drug reconciliation.
- Tube evaluation as moderate.
- Three out of three low moderate level to reach high moderate level.
- Use of “with or without” when describing various conditions.

Title: Creation and Implementation of an Effective Emergency Medicine Coder QA Program – AAPC Approved for 1.5 Core A CEUs, CEDC, CPCO, or CPMA credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:36:26

Whether emergency medicine coding is performed in-house or through an outside agent, almost all coding organizations have a coding quality assurance program that applies internal quality measures meant to ensure appropriate capture of revenue and adherence to compliance rules and regulations. Although the format of these programs varies from organization to organization, an effective program should include both random and focused reviews in order to ensure that code choice is being evaluated in a consistent manner, and that any focused problem areas are being addressed. Dr. John Stimler of Bettinger, Stimler & Associates will review a point-by-point plan for creating and implementing an effective coder QA program that will help identify coder and provider outliers, as well as reveal potential coding methodology issues.

Topics include:

- What every Coding QA Program should include.
- Effective QA Program implementation.
- Random and Focused Audits - Why an effective QA Program should include both.
- Incorporating Business Intelligence into your Coder QA Program
- Parameters to imbed in BI for each E/M code range that balance reimbursement and compliance.
- Outlier identification and training.
- Industry Coding QA Program examples.

Title: Emergency Medicine Coding Reports: The What, The Why, and The How Often Behind the Successful Review and Interpretation of Critical Coding Data – AAPC Approved for 1.5 Core A CEUs, or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 1:30:32

Whether emergency medicine coding is performed in-house or through an outside agent, almost all coding organizations create monthly coding summary reports. Although the terminology and format of these reports varies widely, interpretation of the data in them is key to successfully reviewing code choice from both reimbursement and compliance perspectives. Regular review and analysis of coding reports will ensure that physician groups and coding vendors are evaluating code choice in a consistent manner. We will discuss the critical reports that every ED group and coding organization should be reviewing, how often they should be reviewed, and the relevant emergency medicine and urgent care benchmarking data that will help identify coder and provider outliers as well as reveal potential coding methodology issues.

Topics include:

- The critical coding reports that ED Groups and coding organizations should be reviewing on a monthly, quarterly and annual basis.
- Coding reports examples.
- Successful interpretation and analysis of coding data.
- Code choice benchmarking data.
- Identification of provider and coder outliers.

Title: Urgent Care Evaluation and Management Documentation and Coding – AAPC-Approved for 1.5 Core A CEUs, CEDC, and all specialties except CASCC and CIRCC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 55:59

Urgent Care is the provision of medical and traumatic care in a facility dedicated to more acute care outside of a hospital emergency department. Patients can be treated on a walk-in basis, without an appointment, and receive immediate care. If necessary, stabilization therapy may be provided for emergency condition prior to transfer of a patient to a hospital environment.

Some Urgent Care centers provide services that replicate the great majority of services provided in emergency department. Capabilities may include extensive lab, x-ray and Special Studies such as CT scans and MRIs. The patients evaluated include a large number of moderate to high severity conditions that are “worked up” and managed in an Urgent Care setting.

Higher levels of Medical Decision Making intermixed with appropriately documented Histories and Exams generally result in higher Evaluation and Management code choice. This is especially true when compared

with an office-based practice where limited ancillary studies and management options exist. In an Urgent Care setting, appropriate code choice is vital to ensure maximum reimbursement while maintaining compliance.

Topics include:

- Provider documentation requirements for each E/M code.
- How the medical record can influence the chosen E/M code level.
- How the ancillary studies available at each Urgent Care environment allow for management of more acute patients with higher severity conditions.
- Appropriate E/M code choice in an Urgent Care setting.
- E/M code choice distribution comparisons.

Title: ICD-10 Implementation Series, Part One: Overview for Emergency Medicine Providers and Coders – AAPC-Approved for 1.5 Core A CEUs or CEDC credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:42:35

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part One topics include:

- ICD-10 advantages.
- Differences between ICD-9 and ICD-10.
- ICD-10 myths.
- ICD-10 format, structure and organization.
- Critical provider documentation considerations.
- Critical Coder training considerations.

Title: ICD-10 Implementation Series, Part Two: The Integumentary and Endocrine Systems – AAPC-Approved for 1.5 Core A CEUs or CEDC and all specialties except CPCO, CRHC, CCPC, CPMA, CIRCC and CPMS credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:31:07

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Two topics include:

- The Integumentary System.
- The Endocrine System.
- ICD-9 and ICD-10 comparative code choice examples for Integumentary Conditions.
- ICD-9 and ICD-10 comparative code choice examples for Endocrine Conditions.

Title: ICD-10 Implementation Series, Part Three: The Skeletal System – AAPC-Approved for 1.5 Core A CEUs or CEDC, CANPC, CASCC, CEMC, CFPC, CGSC, CIMC, CPEDC, CPMA, CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 1:53:52
On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Three topics include:

- Skeletal anatomy.
- Skeletal disease review.
- Fracture care codes.
- ICD-9 and ICD-10 comparative code choice examples for skeletal conditions.

Title: ICD-10 Implementation Series, Part Four: The Muscular System – AAPC-Approved for 1.5 Core A CEUs or CEDC, CANPC, CASCC, CCPC, CEMC, CFPC, CGSC, COSC, CIMC, CPEDC, CPMA, CRHC, CSFAC, CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 1:42:22
On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Four topics include:

- Skeletal muscles.
- Skeletal bones.
- Diseases, disorders and other conditions of the Musculoskeletal System.
- ICD-9 and ICD-10 comparative code choice examples for musculoskeletal conditions.

Title: ICD-10 Implementation Series, Part Five: The Cardiovascular System – AAPC-Approved for 1.5 Core A CEUs or CEDC, CANPC, CASCC, CCC, CCVTC, CEMC, CFPC, CGSC, CIMC, CPEDC, CPCO or CPMA credits

Presenter: John Stimler, DO, CPC, CHC, FACEP
Total Run Time: 1:48:12
On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Five topics include:

- Anatomic overview of the heart.
- Blood circulatory system.
- Diseases, disorders and other conditions of the cardiovascular system.
- ICD-9 and ICD-10 comparative code choice examples for cardiovascular conditions.

Title: ICD-10 Implementation Series, Part Six: The Hematologic and Lymphatic Systems – AAPC-Approved for 1.5 Core A, CEDC, CANPC, CASCC, CEMC, CFPC, CGSC, CIMC, CPEDC, CCC, CCVTC, CHONC, CPMA, or CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:29:31

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Six topics include:

- Overview of the blood and blood-forming organs.
- Overview of the Lymphatic System.
- Diseases, disorders and other conditions of the two systems.
- ICD-9 and ICD-10 comparative code choice examples for the Hematologic and Lymphatic systems.

Title: ICD-10 Implementation Series, Part Seven: The Respiratory System – AAPC-Approved for 1.5 Core A, CEDC, CEMC, CFPC, CGSC, CIMC, CPEDC, CCC, CCVTC, CPMA, CENTC or CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:49:05

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Seven topics include:

- Overview of the Respiratory System including anatomy and physiology.
- Respiratory System injuries.
- Diseases, disorders and other conditions of the respiratory system.
- ICD-9 and ICD-10 comparative code choice examples for the Respiratory System.

Title: ICD-10 Implementation Series, Part Eight: The Urinary and Reproductive Systems – AAPC approved for 1.5 CEUs Core A, CEDC, CANPC, CASCC, CEMC, CFPC, CGSC, CIMC, CPEDC, CPMA, COBGC, CUC, or CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:47:17

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Eight topics include:

- Overview of the Urinary System.
- Overview of the Reproductive System.
- Diseases, disorders and other conditions of the Urinary and Reproductive Systems.
- ICD-9 and ICD-10 comparative code choice examples for the Urinary and Reproductive Systems.

Title: ICD-10 Implementation Series, Part Nine: The Nervous System – AAPC approved for 1.5 CEUs Core A, CEDC, CANPC, CASCC, CEMC, CFPC, CGSC, CIMC, CPEDC, CPMA, or CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:38:19

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Nine topics include:

- Overview of the Nervous System.
- Signs, symptoms, and abnormal findings specific to the Nervous System.
- Diseases, disorders and other conditions of the Nervous System.
- ICD-9 and ICD-10 comparative code choice examples for the Nervous System.

Title: ICD-10 Implementation Series, Part Ten: The Digestive System – AAPC approved for 1.5 CEUs Core A, CEDC, CANPC, CASCC, CEMC, CFPC, CGIC, CIMC, CPEDC, CPMA, CHONC, or CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:35:09

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Ten topics include:

- Overview of the Digestive System.
- Signs, symptoms, and abnormal findings specific to the Digestive System.
- Diseases, disorders and other conditions of the Digestive System.
- ICD-9 and ICD-10 comparative code choice examples for the Digestive System.

Title: ICD-10 Implementation Series, Part Eleven: The Eye, Ear and Surrounding Structures – AAPC approved for 1.5 CEUs Core A, CEDC, CPMA, or CPCO credits

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 1:32:13

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Eleven topics include:

- Overview of the eye and adnexa.
- Overview of the ear and mastoid process.
- Diseases, disorders and injuries of the eye and ear.
- ICD-9 and ICD-10 comparative code choice examples for the eye and ear.

Title: ICD-10 Implementation Series, Part Twelve: Wrap Up for Emergency Medicine Coders - AAPC approved for 1.0 CEUs Core A or CEDC credit

Presenter: John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 47:02

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were replaced by ICD-10 code sets. Dr. John Stimler's ICD-10 webinar series intermixes his clinical expertise with the critical anatomy, physiology, and disease reviews that your staff will require to successfully apply ICD-10 codes.

Part Twelve topics include:

- ICD-10 advantages.
- ICD-10 myths.
- General coding guidelines and examples of changes.
- Differences between ICD-9 and ICD-10.
- ICD-10 code sets for common emergency medicine presentations.
- Key points regarding each system covered during the 11-part series.

Title: Monitoring Your Billing Company Performance: Metrics You Need to Measure

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 50:27

The best medical billing metrics give you an instant snapshot of your practice's financial health across many interrelated areas. Identifying these key performance indicators is an important step in implementing medical billing best practices. Emergency medicine billing expert Dr. Jeff Bettinger of BSA Healthcare is offering a one-hour webinar that will help participants to identify the most critical metrics that you should be analyzing across different areas of your practice, and why they matter to billing and collections including:

- Identification of the most common causes of lost revenue.
- Understanding and interpreting routine billing reports.
- Identification of billing problems early on, allowing for successful remedial efforts.
- Identification of payer issues, including down-coding and incorrect payments.
- Understanding the role played by ED physicians in maximizing revenue.

Title: Understanding the Acute Unscheduled Care Model – Emergency Medicine's First Alternative Payment Model

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 44:41

On September 6th, 2018, the Physician Focused Alternative Payment Model Technical Advisory Committee (PTAC) recommended, with priority, the implementation of ACEP's Acute Unscheduled Care Model (AUCM) by CMS- the first APM designed by, and focused on, emergency physicians. This webinar will explain the structure of the AUCM and provide information that emergency groups may use when deciding whether to participate.

Topics to be addressed will include:

- Historical development of the AUCM
- Basic structure of the model
- Effects on the practice of emergency medicine

- Risks and rewards of the model
- Financial modeling required to determine whether to participate in the AUCM
- Non-Medicare potential for AUCM-like APMs

Title: Optimize Your Billing Company Performance: Critical Reports You Need to Watch
Presenter: Jeffrey Bettinger, MD, FACEP
Total Run Time: 51:26
This webinar will enable physicians and practice managers to analyze and interpret routine billing reports, and then use this knowledge to enhance collections.

Topics include:
- Aging reports.
- Reports that tie collections back to the month of charges.
- Cash receipts and charges reports.
- Encounter tracking reports.
- Time-to-collect reports.

Title: The Collection Agency Processes: The Black Box of the Revenue Chain
Presenter: Jeffrey Bettinger, MD, FACEP
Total Run Time: 18:47
The collection agency process begins when self-pay accounts receivable is written off of active accounts receivable and put in a file to be sent to the collection agency. General statistics regarding collection agency placements for emergency physician services are essentially not available. This webinar, designed for the physician executive or practice manager, allows the participant to understand the factors that will improve collection agency performance, and teaches the participant how to choose an appropriate collection agency.

Title: Managed Care Contracting – Evaluating Strategies, and Negotiating Your Way to Success – A 2-Part Webinar Series
Presenter: John Stimler, DO, CPC, CHC, FACEP
Part 1 - Total Run Time: 1:10:16
Part 2 - Total Run Time: 1:01:53
Because so many patients are covered by some type of managed care plan, the majority of physicians participate in managed care contracts; however, while virtually all health insurance provided by employers is available to individuals in the private insurance market, emergency care services are subject to EMTALA laws that mandate the provision of care to every patient who presents to an ED, even if a patient's insurer refuses to pay fairly, or negotiate favorable contract rates. Non-financial issues also play a role in managed care contract negotiations. Emergency physicians are often subject to payers who leverage their relationship with a hospital to coerce emergency physicians to accept deeply discounted, below-market rates for emergency physician services, or risk losing their hospital-ED staffing contract.

Solid managed care contracts are the foundation of a reliable revenue stream for many ED Groups. Poorly negotiated contracts can cost providers hundreds of thousands of dollars, making preparation before, during, and throughout the term of a managed care contract key to the success of an ED Group practice.

Topics include:

- Historical problems with Managed Care Organizations.
- MCO contract review
- Managed Care negotiations - preparation.
- Managed Care negotiations - strategy.
- Contracting terms that could negatively impact your business.
- Fee Schedule considerations.
- Tracking and trending denials data.
- PHO background information and consideration.

Title: Valuation of Emergency Physician Accounts Receivable

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 34:51

This webinar will teach practice managers, group principals, and investors how to accurately value accounts receivable by using standard billing reports.

Topics include:

- Emergency Physician (EP) group sale.
- EP group acquisition.
- EP groups merger.
- Buy/sell agreements among group members.
- Loans or line of credit.
- Initial public offerings.
- Taking a publically traded EP company private.
- Lawsuits.

Title: Setting an Emergency Physician Fee Schedule

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 17:24

Maintaining an adequate provider fee schedule is one method emergency groups can use to improve collections. Commercially available databases can be a useful resource when setting a provider fee schedule. If accurately constructed, commercial databases can be the precise and defensible resource when setting a fee schedule.

Topics include:

- CPT code charges.
- Fee sharing.
- Fee schedule databases.
- Payments and actual charges.
- Emergency medicine fees.

Title: 2021 Medicare Physician Fee Schedule Proposed Rule and Updates on Out-of-Network Reimbursement

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 32:17

The Centers for Medicare and Medicaid Services (CMS) released the proposed 2021 Medicare Physician Fee Schedule (MPFS) on August 4, 2020. The proposed rule includes annual updates to the relative weights of physician services, as well as other items that will impact physician fees.

In order to help emergency physicians, hospitals, and the vendors who serve both prepare for the anticipated changes to emergency medicine reimbursement, Dr. Jeffrey Bettinger of BSA Healthcare is offering a 45-minute webinar dedicated to the following topics:

- Emergency Medicine RVUs and fee schedule, including large RVUwork increases for emergency services
- Conversion Factor Updates, including a 10.5% budget neutrality reduction
- Change in payment policy for office visits - negative effects for emergency medicine
- Out-of-network legislation
- Emergency medicine-specific alternative payment models

Title: 2020 Medicare Physician Fee Schedule Proposed Rule and Updates on Out-of-Network Reimbursement and Alternative Payment Models Updates

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 37:29

The Centers for Medicare and Medicaid Services (CMS) released the proposed 2020 Medicare Physician Fee Schedule (MPFS) on July 29, 2019. The proposed rule includes annual updates to the relative weights of physician services, as well as other items that will impact physician fees.

In order to help emergency physicians, hospitals, and the vendors who serve both prepare for the anticipated changes to emergency medicine reimbursement, Dr. Jeffrey Bettinger of BSA Healthcare is offering a 45-minute webinar dedicated to the following topics:

- Emergency Medicine RVUs and fee schedule, including changes to Malpractice RVUs
- Conversion Factor Updates
- Change in payment policy for office visits - potential negative effects for emergency medicine
- Changes in Medicare documentation guidelines for office visits
- Out-of-network/fair coverage advocacy and public relations
- Emergency medicine-specific alternative payment models.

Title: 2019 Medicare Physician Fee Schedule Final Rule and Alternative Payment Models Updates

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 40:26

On September 6th, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended - with priority - that ACEP's Acute Unscheduled Care Model (AUCM) be fully implemented by Medicare. This critical step starts the process whereby the Innovation Center of CMS will evaluate AUCM and determine whether Medicare will implement the model.

Dr. Bettinger's webinar will address the following:

- Emergency Medicine RVUs and fee schedule
- Conversion factor updates
- Misvalued codes, including emergency service evaluation and management codes
- Revision of documentation guidelines

- Out-of-network/fair coverage advocacy and public relations
- PTAC-approved emergency medicine-specific alternative payment model
- Basic description of the ACEP AUCM model
- Timeline for potential implementation
- Options that Medicare may choose regarding implementation
- Basic financial underpinning of model
- Upside benefits and downside risks
- Potential effect on Medicare fee-for-service revenue outside of the model
- Potential effect on MIPS
- Considerations that ED groups should address in 2019

Title: 2019 Medicare Physician Fee Schedule Proposed Rule and Updates on Out-of-Network Reimbursement and Alternative Payment Models

Presenter: Jeffrey Bettinger, MD, FACEP

Total Run Time: 36:33

The Centers for Medicare and Medicaid Services (CMS) released the proposed 2018 Medicare Physician Fee Schedule (MPFS) on July 12, 2018. The proposed rule includes annual updates to the relative weights of physician services, as well as other items that will impact physician fees.

In order to help emergency physicians, hospitals, and the vendors who serve both prepare for the upcoming changes to emergency medicine reimbursement, Dr. Jeffrey Bettinger of BSA Healthcare is offering a 45-minute webinar dedicated to the following topics:

- Emergency Medicine RVUs and fee schedule
- Conversion Factor Updates
- Misvalued codes
- Change in payment policy for office visits
- Possible future changes in Medicare documentation guidelines
- Out-of-network/fair coverage advocacy and public relations
- Emergency medicine-specific alternative payment models.

Subscription #4: Hospitalist Medicine Provider Documentation and Coding Webinar Library

Essential Documentation Pearls for the Hospitalist Provider

Presented by: Dr. John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 27:47

The first step in ensuring maximum reimbursement for hospitalist services is in training providers in the nuances of proper medical record documentation. Given the inherent environment of the average hospital, it is easy to overlook the significance of proper completion of the medical record. Poor documentation precludes the ability to code a specific service and can result in down-coding of a visit to a lesser code. This webinar will educate hospitalist providers on proper chart documentation requirements intended to prevent documentation deficiencies and concomitant revenue loss.

Topics include:

- Documentation of a comprehensive History and Exam

- Time documentation
- Critical Care case types
- Problems list
- Documentation of orders
- Complications
- Subsequent Visit documentation
- MDM issues
- Procedures
- Counseling and coordination of care.

Critical Care Overview for the Hospitalist Provider

Presented by: Dr. John Stimler, DO, CPC, CHC, FACEP

Total Run Time: 28:07

Critical care billing is justified if a patient has a medical condition that "impairs one or more vital organ systems" and "there is a high probability of imminent or life-threatening deterioration in the patient's condition" provided a physician has provided "frequent personal assessment and manipulation" of the patient's condition. The key to collecting adequate reimbursement for Critical Care is in first recognizing Critical Care-type cases, and then documenting Critical Care time of 30 minutes or greater. This webinar will focus on proper reporting of Critical Care codes 99291 and 99292, and patient presentations and specific case types that - assuming proper CC time documentation as a baseline - qualify for Critical Care.

Topics include:

- Critical Care definition
- Time requirements
- Medicare reporting requirements
- Critical Care scenarios
- Critical Care procedures.

Title: Hospitalist E/M Coding Explained – Part 1

Presenter: John Stimler, DO, CPC, CHC

Total Run Time: 40.43

While thorough documentation is the baseline, the second step in ensuring maximum reimbursement for hospitalist services is in training providers and coders in the nuances of proper coding. The chosen MDM level is used in conjunction with the History and Exam levels to assist coders in determining the proper Evaluation and Management code for hospitalist services, but the requirements are detailed and specific. Hospitalist coding also requires a clear understanding and knowledge of inpatient E/M service codes, as well critical care and observation services codes. Designed to address the most common hospitalist documentation and coding errors we have encountered as hospitalist coding auditors, this 2-part webinar will educate hospitalist providers on chart documentation and coding requirements for the different E/M levels with the intention of preventing revenue loss and compliance issues.

Topics covered in Part 1 of this two-part hospitalist coding webinar series include:

- Medical Decision Making (MDM)
- Complexity tables
- Patient status.

Title: Hospitalist E/M Coding Explained – Part 2

Presenter: John Stimler, DO, CPC, CHC

Total Run Time: 1:01:21

While thorough documentation is the baseline, the second step in ensuring maximum reimbursement for hospitalist services is in training providers and coders in the nuances of proper coding. The chosen MDM level is used in conjunction with the History and Exam levels to assist coders in determining the proper Evaluation and Management code for hospitalist services, but the requirements are detailed and specific. Hospitalist coding also requires a clear understanding and knowledge of inpatient E/M service codes, as well critical care and observation services codes. Designed to address the most common hospitalist documentation and coding errors we have encountered as hospitalist coding auditors, this 2-part webinar will educate hospitalist providers on chart documentation and coding requirements for the different E/M levels with the intention of preventing revenue loss and compliance issues.

Topics covered in Part 2 of this two-part hospitalist coding webinar series include:

- History and Exam requirements
- Hospitalist E/M code choice summary
- Documentation deficiency code results
- Interval history
- Discharge services
- Observation care
- Unit/floor time
- Consultations.