Seven Surefire Ways to Start a Nonphysician Practitioner Off Right

With the proper planning and preparation, nonphysician practitioners (NPPs) can improve physician productivity and increase patient access to the practice. A thorough training and orientation program is vital to optimizing the effectiveness and retention of an NPP. An organized approach to understanding payer reimbursement guidelines will ensure that his or her services are documented and billed correctly, and paid appropriately. And proper communication and marketing will go a long way toward building the NPP’s patient base. This article offers seven proven ideas for getting an NPP off to a great start in any physician practice.

Read Full Article
You’ve made the strategic shift toward increasing cosmetic lines of service. You’ve developed a solid infrastructure to support your vision. The final and most important philosophy to adopt as you build a cosmetic dermatology practice is this: when you acquire a cosmetic patient, make it your goal to keep them for life.

Read Full Article
We Just Had Our Two Most Profitable Months Ever!

KZA Success Profile – January 2015
by Cheryl Toth, MBA

We love receiving emails like these from aesthetic practices that have successfully integrated what they learned at a KZA workshop.

Melissa Peterson, Patient Care Coordinator for John Wakelin, MD at Columbus Aesthetic & Plastic Surgery recently sent an enthusiastic note telling us that Dr. Wakelin had his two most profitable months since starting practice 10 years ago.

Read Full Article

Colectomy Coding

Question:

A general surgeon asked me to assist in a colectomy where he had inadvertently nicked a mesenteric artery. I entered the
case and did a direct repair of the artery. Should I bill as
his assistant or co-surgeon and what modifier should I use?

Answer:

In this case, you would not bill as an assistant or a co-
surgeon. You would bill for the work you did, direct repair of
an abdominal vessel (35221), without a modifier. A colectomy
code is not valued to include repair of an artery, so billing
as assistant or co-surgeon would not be appropriate. You will
bill only for the specific work that you did: repairing the
artery.

Removal and Reinsertion of
Cages

January 22, 2015

Question:
Our surgeon documented a revision of an interbody fusion and
wants to report 22849 for the removal of a cage and placement
of a new cage. Is this an acceptable use of the re-insertion
code?

Answer:
Great question and one that is not uncommonly asked in the
Orthopaedic Coding courses presented by Mary LeGrand and Margi
Maley. CPT code 22849 is not appropriate to report in this
scenario. If the surgeon’s documentation supports a level of
complexity over and above for the revision interbody fusion,
the possibility of appending modifier 22 for the increased
procedural service and complexity exists.
Ear Canal Debridement...Again

January 22, 2015

Question:

What CPT code would I use for a debridement of purulent debris from the ear canal, with or without placement of a wick in, such as when the patient has Swimmer’s ear? One of my colleagues told me he bills cerumen removal (69210) because there is always a little bit of cerumen mixed in the debris. I thought I’d better check on that.

Answer:

Good idea to check! CPT 69210 (Removal impacted cerumen requiring instrumentation, unilateral) requires the cerumen be impacted and the diagnosis should be 380.4 (Impacted cerumen). If the diagnosis is really Swimmer’s ear and there is “a little bit” of cerumen, then it doesn’t seem right to use 69210 with a diagnosis of 380.4. There is not a CPT code for ear canal debridement for Swimmer’s ear. This service is considered part of the E&M code you will report for that visit. However, if you used the microscope for the diagnosis and treatment then you could also report 92504 (Binocular microscopy (separate diagnostic procedure)).

Epidermal Cyst

January 22, 2015
Question:

Hello, I was at an ASPS coding conference last year and loved what Kim Pollock had to say! She did a great job and was very informative, I learned a lot from her that weekend.

I have a question and was hoping you could give me some insight on it. When coding for a lesion/mass excision removal I know that you code by the size and the location of the lesion/mass but when it comes to depth I am a little confused. The patient has a ruptured epidermal cyst (per the pathology report) removed from the eyebrow/eyelid area and the doctor goes down to and included the oculi muscle to excise it. Would I code from the integumentary system (114xx) or from the musculoskeletal system (e.g., 21012-21014). I am leaning toward the excision of skin (integumentary) codes because the origin of the cyst is from the dermis or epidermis and you would code those from the integumentary system….at least that’s what I heard Kim say at the conference. But because the excision was down to and included the oculi muscle I want to make sure that I wouldn’t code it the musculoskeletal system codes.

Thanks for any help you can provide!

Answer:

Thank you for your kind words — I very much appreciate it! You’re right — you’d use the integumentary system code (114xx) in this situation because the epidermal cyst is of cutaneous origin. The codes in the musculoskeletal system (2xxxx) are for tumors that are non-cutaneous in origin such as lipomas. The depth of the excision, while it clearly makes the procedure more difficult, does not have a bearing on the code. It’s the origin of the lesion/tumor that drives the code choice.
Co-Surgery Modifier (62) on Spinal Instrumentation

January 22, 2015

Question:

Hi, I have a case where I have two surgeons who did a fusion together. The codes were all billed with modifier 62. The commercial insurance denied for modifier 62 with code 22842. As I research, I realize CPT states modifier 62 is inappropriate with 22842, although I see that CMS payment policy still allows modifier 62 to be paid. As I read the report, I see that each surgeon did distinct parts – one surgeon did the right side while the other did the left pedicle screws/rod placement. Should I appeal the denial?

Answer:

No, you should not appeal the denial of 22842-62. Physicians are to follow CPT coding guidelines, which do not allow appending modifier 62 to the spinal instrumentation codes. Therefore, it is not appropriate to bill in this manner or expect to be paid.

Weekend Rounding

Question:

I have question regarding weekend rounding. I share weekend call with another practice that I am not affiliated with.
Sometimes, when rounding, I check on 5-10 of their post-op patients. Since I am not part of their practice, is this something I can bill for? If so, should I bill a consult or a follow-up visit?

**Answer:**

Good question. You should not charge for rounding on their post-op patients and they shouldn’t charge for rounding on yours. You should treat the patients as if they were your own...and you would not bill for routine post-op care on your own patients.

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**Diagnostic Arthroscopy and Meniscectomy**

January 8, 2015

**Question:**
Can I report a right meniscectomy and left diagnostic knee arthroscopy during the same session?

**Answer:**
Yes, CPT code 29881 (meniscectomy) and CPT code 29870 (diagnostic arthroscopy) are reportable during the same operative session when they are independently performed on different knees. Use of modifiers may be payor dependent. According to CPT rules, you would report 29881 and 29870-59. Some payors may want the RT/LT modifiers alone; some payors may want the RT/LT and the 59. In 2015, the “X” modifier for separate structure might be required.