Learn the Latest in Otorhinolaryngology Coding

AAPC News – March 2017
by Kim Pollock, RN, MBA, CPC, CMDP

CPT® 2017 captures the most up-to-date clinical services for ear, nose, and throat specialists.

CPT® 2017 brings several code changes for otorhinolaryngology, a specialty that has seen few, if any, code changes in the past several years. The changes are primarily new codes, with some code revisions, to keep the codes up to date with contemporary clinical practice.

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Stay Current with Spine Procedural Coding

AAPC News — May 2017
by Kim Pollock, RN, MBA, CPC, CMDP

See how spine procedure codes, guidelines, and reporting have changed in 2017.

There are many 2017 CPT® code changes pertaining to spine procedures. Here’s a rundown of the most significant changes.

Removal of Moderate Sedation Inclusion
The moderate sedation symbol («) was removed from the vertebro-plasty (22510-22512) and vertebral augmentation (22513-22515)

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CPT® tells us when not to separately report the use of an operating microscope. We’ll tell you when you should.

Many otolaryngologists use an operating microscope when performing ear procedures in the operating room. Coders often wonder if it is acceptable to report CPT® +69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure) in addition to the primary ear procedure code.

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2017 Spine CPT Code Changes
Spine surgeons face a multitude of Current Procedural Terminology ® (CPT) code changes, effective Jan. 1, 2017. This article provides a summary of these changes so practices can get a head start on understanding their implications. A complete listing of changes can be found in the 2017 CPT manual.

**Approach and Visualization Definitions**

The Spine and Spinal Cord section of the Nervous System codes in CPT 2017 provides new definitions of key terms and surgical approaches to further clarify these CPT code descriptors, as shown in Table 1.

Surgical CPT codes are presumed to be open unless the code descriptor states otherwise.

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Medicare eliminated payment for consultations in 2010, which resulted in significant revenue losses for spine surgeons and
all specialists. All office consultations for Medicare patients became a new or established patient, or an emergency department visit if the patient was seen in the emergency department, which is an outpatient facility.

Due to this change, payment for these visits was reduced 20% or more. Inpatient consult revenue for Medicare patients was also lost. For inpatients, this meant spine surgeons must code an initial hospital care code or a subsequent hospital care code in lieu of an inpatient consultation code, depending on the circumstances.

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Spine Surgery Quandary: Posterior Lumbar Interbody Fusion

When do you bill 63056-59 with 22633, rather than 63047-59?
A common question among coders and spine surgeons is whether to bill 63056-59 with 22633, or 63047-59. The answer is complex, but CPT® and Medicare guidelines provide essential guidance.

The Revenue Engine that Could “Think You Can” by Refining the Revenue Cycle with the Right People, Processes, and Tools

Many physicians continue to wrestle with an economy-in-recovery and declining reimbursements. In this business climate, practices can’t afford reimbursement process mistakes and inefficiencies; they’re simply too expensive. Just a few
denied surgical claims can cost a practice thousands of dollars. That’s the cost of the annual electronic health care records licence or the T1 line. Uncovering any and all opportunities to improve the speed and efficiency of getting paid can positively contribute to the bottom line. This article reiterates the basics and “best” practices for efficient revenue cycle operations. The goal is to have the right tasks performed by the right number of people at the right time and with the right tools to optimize revenue.

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Follow an Eight-Step Formula for Correct Spine Coding

Follow an Eight-Step Formula for Correct Spine Coding – September/October 2014
by Teri Romano, RN, MBA, CPC, CMDP and Kim Pollock, RN, MBA, CPC, CMDP

As part of the new Spine Coding Source column, Spine Surgery Today will begin discussing relevant spine coding issues for surgeons. We hope this new feature will enhance your practice and help clarify areas of difficulty. We are pleased to work with coding experts, KarenZupko & Associates. Our goal is to provide our readers with up-to-date coding changes and practice optimization tools. We look forward to your comments and suggestions for future topics.

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“It seems like coding spine cases is as complicated as doing the surgery,” said a spine surgeon at his first coding training session with me.

Spine procedure coding can make even the most confident coder squirm. But spine procedure coding doesn’t have to be difficult. In fact, it’s quite formulaic. Follow these five principles and spine procedure coding will go from scary to simple.

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Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery

The American Medical Association’s Current Procedural Terminology® (CPT) codes for reporting medical services and procedures performed by physicians must be used to bill services to third party payers. The contemporary practice of medicine is occasionally ahead of the CPT code system and an accurate code may not always exist for the procedure performed; this is true for reporting most endoscopic/endonasal skull base surgery procedures.

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