Is Your Practice Not Getting Paid?

AAOSNow – July 2017
by Michael R. Marks, MD, MBA, and Cheryl Toth, MBA

Coding May Not Be the Reason

It’s easy to blame a practice’s skyrocketing accounts receivable (A/R) on coding and the insurance companies. But our experience with orthopaedic practices, and the results of AAOS/KarenZupko & Associates (KZA) pre-workshop surveys on coding and reimbursement, indicate that the problem is a lot more complex.

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Michael R. Marks, MD, MBA

Cheryl Toth, MBA
9 Mistakes You Don’t Want the Patient Care Coordinator to Make

Looking to build the skills of a newly hired Patient Care Coordinator (PCC)? Need an objective approach for showing the PCC how to polish her professionalism? Want to help your PCC go from good to great?

This article offers some options.

It covers the most common mistakes we observe PCCs making while interacting with patients. They are so common, in fact, that even PCCs themselves recognize them. When we cover this topic in our aesthetic practice workshops, the discussion is a lively learning experience for everyone.

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Medicare Sharpens Focus on the Global Surgical Package

The Centers for Medicare & Medicaid Services (CMS) has expressed concern that services with 10- and 90-day postoperative periods are not valued accurately, and follow-up visits included in the value of the global services are not consistently being performed. Consequently, as required by the Medicare Access and CHIP Reauthorization Act (MACRA), CMS mandated the reporting of postoperative visits for 293 Current Procedural Terminology (CPT) codes for providers in the following nine states beginning July 1, 2017:

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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, CMDCP

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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“Sorry, I didn’t call you back last week, Karen. I was climbing mountains in Nicaragua.”

That was the message that New Orleans plastic surgeon John Church, MD, left for me after my call requesting an interview.

What a perfect message and precursor to the fascinating, motivating, and instructional conversations I’ve had with nearly a dozen plastic surgeons who have transitioned from active practice — and one who returned to recreate a practice.

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Increasingly, pain management specialists—physical medicine and rehabilitation specialists or anesthesiologists—are joining orthopaedic groups that have adopted a more global approach to musculoskeletal system care. However, this presents challenges for the billing time, particularly with respect to coding procedures and transfers of care from the orthopaedists to their pain colleagues. The coding team at KarenZupko & Associates shared the following frequently asked questions.
Effective Jan. 1, 2017, “FX” is a new Medicare modifier used to indicate that X-ray images were taken using film. The FX modifier is appended to the global radiology code or the radiology code with the modifier TC (technical component) when submitting Part B claims to Medicare and using film instead of capturing X-ray images digitally. If your images are in digital format, you do not need to change your reporting at this time. Medicare reduces payment amounts under the Physician Fee Schedule (PFS) by 20 percent of the technical component when the FX modifier is appended. If a global radiology code is submitted (the X-ray code without a 26-modifier indicating the professional component or TC-modifier) a 20 percent reduction is taken off the technical component only (Table 1).
“Can This Marriage Be Saved?” was a McCall’s Magazine column I used to read with great fascination as a teenager. Each month, a psychologist would address questions from real readers whose marriages were on the rocks. The problems were frequently related to miscommunication, money, incompatibility, or the children. In most cases, the marriage was a risk of falling apart because the couple had not taken the time to set expectations, clarify what each of them really wanted, or have an open and honest conversation.

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Every autumn, the American Medical Association’s (AMA) Current Procedural Terminology (CPT) book is updated with changes for the next year. In 2016, minimal changes were made, possibly due to the implementation of the International Classification of Diseases, 10th edition (ICD-10) and a desire to not overload physician practices. In a prior article, 2017 changes for the spine area were presented. (See “2017 Spine CPT Code Changes,” AAOS Now, November 2016.) This column points out the CPT changes made for the foot and toes region.

In summary, effective Jan. 1, 2017, two new codes—28291 and 28295—have been established to report bunionectomy procedures, three codes—28290, 28293, and 28294—have been deleted, and six codes—28289, 28292, 28296, 28297, 28298, and 28299—have been revised.

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