Top 10 HIPAA Mistakes for Practices to Avoid

The Health Insurance Portability and Accountability (HIPAA) Act of 1996 continues to challenge every medical practitioner. A recent discussion on the current state of HIPAA revealed the top 10 mistakes that practices make during implementation.

This year has been rough in terms of privacy. The Office of Civil Rights (OCR) has consistently levied stiff financial penalties on those who violate HIPAA rules. Hacking and ransomware attacks are more frequently in the news. If the confidentiality of patient medical records is not to become a quaint idea of a bygone age, practices need to be proactive. The following mistakes can be avoided, putting your practice on the way to patient privacy protection and HIPAA compliance.

No. 10: Failure to have Business Associate Agreements in place
A Business Associate is a person or entity to whom you provide patient information. These may include third-party billing companies and the service that shreds old documents. Most practices have many Business Associates. The OCR has a free online Business Associate Agreement template that can easily be downloaded.

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Six Steps Ways to Build the Practice ‘Brain Bank’
1. Develop a new employee orientation/onboarding program.

Go beyond the completion of human resources paperwork. An orientation/onboarding program provides new employees with a broad understanding of your organization’s vision, culture and overall practice operations. An effective orientation plan includes items such as:

- a welcome lunch with a small group of staff and at least one physician;
- meeting with the manager to get an overview of current and planned projects;
- meeting with the managing partner to learn about mission, vision and goals of the practice;

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Documentation Guidelines for Medical Decision Making

Margaret Maley, BSN, MS

Documentation Guidelines for Medical Decision Making – August 2017
by Margaret M. Maley, BSN, MS
With a brief history of their development
Thousands of pages of regulation have been generated since the American Medical Association (AMA) first introduced Evaluation and Management (E/M) codes to describe inpatient and outpatient visits in 1992. When originally published, the E/M code descriptors were ambiguous and unclear, resulting in the reporting of erroneous levels of service and the inability to audit or oversee the delivery of services to Medicare beneficiaries.

In 1995, the Centers for Medicare & Medicaid Services (CMS) revised the E/M guidelines to include more specific details about the patient history and the extent of the physical examination. That same year, the AMA and the Health Care Financing Administration (now CMS) introduced their collaboration on the development of E/M documentation guidelines. The AMA emphasized that guidelines were created for the following reasons:

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Got a Good Governance Agreement? Use This 12-Point Checklist to Find Out
A governance agreement is a written directive for how a practice’s board of directors is comprised and how it operates. Governance is the way in which an organization polices itself, and a good agreement includes a number of things that allow your practice to do that effectively. Decision-making policies, meeting procedures and board role definitions are a few examples.

Is Your Practice Not Getting Paid?

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.
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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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
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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Profiles in Plastic Surgeons’ Practice Transitions
“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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