Wise individuals know their area of expertise and know when they need expert advice. For surgeons, building a team of trusted advisors is as important to their personal and professional success as building a team of top-notch employees is to the success of their practice.

Engage these five important advisors who can guide you throughout your career.

**Health care attorney**

Many surgeons starting out in practice will join a hospital or group as an employed physician. The employment agreement you will be offered is a legal document that sets the stage for your income potential and practice growth. Reviewing it is not the time for do-it-yourself or to ask a favor of your brother-in-law’s lawyer friend who practices family law. You will likely review an employment agreement fewer than five times in your career; hospitals and large medical groups have a team of people who do it daily. This is not the time to skimp. Hire a health care attorney to review the agreement and advise you on
High Deductible Health Plans: Take Accounts Receivable Action Now

The facts in these stories and the 2017 Employer Health Benefits Survey, released on September 19 by the non-partisan Kaiser Family Foundation and Health Research & Educational Trust (HRET), are alarming. Let’s look at some of the survey results.

Since 2007, the average family premium has increased 55% and the average worker contribution toward the premium has increased 74%. How does that translate into dollars and cents? Well, the average annual premiums this year are $6690...
for single coverage and $18,764 for family coverage.

Dispensing DME in Orthopaedics for Medicare

Sarah Wiskerchen, MBA, CPC

Dispensing DME in Orthopaedics for Medicare – November 2017
AAOSNow
by Sarah Wiskerchen, MBA, CPC

Answers to key coding questions
Orthopaedic practices often provide patients with supplies, such as casts and canes, integral to patients’ treatment plans.

This article covers the essentials of coding and claims submission. Understanding the definitions and rules for DME can help practices make more effective decisions on which supplies to offer patients as well as help them ensure that items are both accurately reported and appropriately paid.

The article also focuses on Medicare policy, which applies nationally.
Q. What exactly is DME?

DME—durable medical equipment—is often used to refer to a range of supplies and assistive devices that are dispensed in a healthcare setting. However, not all of these items are classified as DME within the coding system used for billing.

According to the Centers for Medicare & Medicaid Services (CMS), DME is “medically necessary durable medical equipment, prosthetics, orthotics, and disposable medical supplies (DMEPOS), which includes oxygen and related supplies, parenteral and enteral nutrition, and medical foods.” DME is primarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient’s home. In some cases, DME items are rented, but in orthopaedics they are usually purchased.

Q. What supply items might be used in an orthopaedic office? How does a coder know which codes to use?

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Medical Imaging and HIPAA Compliance
AAOS Now – October 2017
By: Michael R. Marks, MD, MBA

What orthopaedic surgeons need to know

Last month, I coauthored an article on Health Insurance Portability and Accountability Act (HIPAA) compliance that offered tips on how orthopaedic practices can keep their patients’ information safe (see “Top 10 HIPAA Mistakes to Avoid, AAOS Now, September 2017). In this article, I speak with Les Trachtman, CEO of Purview, a patient-driven healthcare technology company, about medical imaging and HIPAA compliance.

Dr. Marks: Do orthopaedic surgeons need to be concerned about medical imaging and potential HIPAA implications?

Mr. Trachtman: Although medical imaging may not be the primary focus of HIPAA or the Health Information Technology for Economic and Clinical Health Act (HITECH), medical images are considered protected health information (PHI). Often much larger than their medical record counterparts, medical images are typically dense data files that may exceed a gigabyte in size. Because storage, sharing, and archiving of medical images pose unique challenges for practitioners, it is important to understand how to best manage this information without running afoul of regulations.

Read Full Article
To charge or not to charge? That is the question many aesthetic surgeons and their staff ask about paid consultation fees.

Some are concerned that if they charge, patients will schedule with a free “cosmetic surgeon” across town. Others use the excuse, “Everyone else is free—so how can I charge?” Younger surgeons worry they won’t build a patient base if they don’t offer free consults. And, then there are the confident, self assured surgeons who see their consultation as a real service for which they’ve earned compensation.
Help your practice stand out by recognizing what makes it unique in the marketplace.

“The doctor is board certified.” This is the answer I hear most often when I ask a new practice manager what makes her practice unique or special. While being board certified is an important credential that potential patients are wise to verify and value, there are thousands of board certified plastic surgeons and dermatologists nationwide, so it’s not that “unique.” In fact, in some urban areas it’s common to have 12 or more board certified aesthetic specialists in a three-block radius—and five or more in the same high-rise building. So, let’s back up a minute and take a look at the meaning of the word unique. Merriam-Webster’s Dictionary defines it as “being the only one” and “being without a like or equal.”

Read Article
Avoid These Five Reasons that Front-Desk Collections Fail

With the number of patients who have high-deductible health plans that are climbing even higher, many practices are moving toward an up-front, point-of-service collections model. Our firm has advocated this for decades. When front-desk collections are implemented correctly, we see significant increases in daily revenue and a reduction in accounts receivable of more than 90 days old.

However, when implementation is not executed well, we find that the initiative often fails, and staff returns to collecting copays and telling patients they’ll be billed after insurance pays.

Here are five common reasons for front-desk collection failure, and how to avoid them:

1. Vague rules, no procedures
The amount to collect varies by payor and patient type, benefit level and service provided. If you don’t provide staff with granular rules about what to collect from each type of patient, don’t be surprised if they don’t ask for payment at all.

Create clear rules and procedures. First, define the amount collected and how it varies whether a patient is covered by a contracted plan vs. Medicare vs. out of network vs. uninsured vs. has a high-deductible health plan. All the amounts in these situations could be different.

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7 Things to Consider When Retiring from Practice

Karen Zupko, President

Physicians Practice – September 27, 2017
by Karen Zupko

Preparing for retirement can be challenging for any busy professional. But for physicians, the challenge goes beyond office closure procedures and financial details. Of course you’ll contact the state medical society, board of medicine,
and Drug Enforcement Agency to verify rules about how long to keep records, financial data, and licenses. And practice closure checklists are plentiful.

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**Six Steps for Conducting an Internal Evaluation & Management Audit**

Sarah Wiskerchen, MBA, CPC

**Six Steps for Conducting an Internal Evaluation & Management Audit**

*Healio Orthopedics • Orthopedics Today – September 2017*

by [Sarah Wiskerchen, MBA, CPC](#)

Evaluation and management coding patterns are under the microscope. CMS is monitoring evaluation and management code usage by specialty, state and nationally. The Recovery Audit Program of CMS aims to identify and correct improper Medicare payments through the detection and collection of overpayments. Commercial payers are using analytics to identify potentially inaccurate coding, too; take-backs may result.
An annual review of each provider’s evaluation and management (E/M) code usage is essential to effectively manage the audit risk of your practice. The process of reviewing documentation identifies coding pattern or usage anomalies – possible non-compliance. This, in turn, uncovers opportunities for educating physicians and staff on how to properly document, code and bill for services according to federal, state and payer guidelines.

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Work RVU compensation formulas and surgery modifiers: To discount RVUs or not

Sarah Wiskerchen, MBA, CPC

Orthopedics Today – September 2017
by Sarah Wiskerchen, MBA, CPC
In hospital employment settings, as well as large groups, work relative value unit-based compensation agreements and formulas are often standard. Understanding how work relative value units are credited is an essential element of creating or negotiating relative value unit-based compensation. Our firm has found there is no single method applied within physician organizations that use relative value unit-based compensation. This article explains why some work relative value unit reductions make sense and others should be carefully addressed with administrators.

Since 1992, many physician organizations have used work relative value units (RVUs) as a methodology for physician productivity and as an element of their physician compensation formulas. Work RVUs are published annually as part of the Resource-Based Relative Value Scale (RBRVS) developed by the CMS.

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