One area of practice administration where most plastic surgery practices make poor decisions is in how and when to disconnect their fees. Surgeons make responsible decisions caring for patients using evidence-based medicine — yet fail to apply evidence-based management principles when it comes pricing their services.

Why is it that some plastic surgery practices choose to compete solely on price? Offering “we’ll match that quote!” language when answering prospective patient email inquiries — from virtual strangers — makes them look less professional and more like car dealers. Racing for the bottom is a no-win situation.

But the reality is, competition can be fierce and intimidating. Pricing is a key element of every product and service on the market. So, what insights can we gain from marketing experts? Perhaps borrowing some smart pricing strategies can enhance both your brand and your bottom line.
Leverage technology and implement time-saving protocols

After your employees, an orthopaedic surgery practice’s two most valuable resources are time and money. In the United States, nearly 40 percent of insured adults are on a high-deductible health plan (HDHP). As a result, an increasing percentage of receivable (A/R) balances are the patient’s responsibility. When improperly managed, these balances are difficult to collect and consume large amounts of the billing staff’s time.

A survey of AAOS/KarenZupko & Associates, Inc. (KZA) workshop attendees illustrates what successful practices are doing to leverage technology, implement time-saving protocols, and
proactively collect patient balances.

**Promote the online patient portal for pre-registration**

The key to collecting for services starts with capturing complete and accurate demographic and insurance information. The practice uses this information to verify eligibility, retrieve benefit information, and estimate the patient’s responsibility for the upcoming appointment. Half of the survey respondents offer their patients an online portal so they can pre-register for an appointment.

In the absence of an online patient portal, practices can collect the necessary information during a phone call prior to the patient’s appointment.

*Read Full Article*

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**When Loyalty Becomes a Liability**

*Karen Zupko, President*

*When Loyalty Becomes a Liability*

*Healio ⋅ Orthopedics Today – March 2018*
by Karen Zupko, President

I was approached by an orthopedic client at a recent conference. Our firm had conducted a revenue cycle assessment for his solo practice. He told me we had issued a good report with lots of practical ideas for improvement. The problem was he couldn’t get the staff to implement any of them. They would not/could not/did not want to do anything differently and were unreceptive to his requests for new technologies and billing process changes. As the physician did not want to upset the staff, he didn’t push things, but he told me it was like being tethered to a ball and chain. Still, the staff wouldn’t budge. Ultimately, cash flow crumbled and managing the practice became too frustrating, so he took an employment offer from a large group and everyone in the practice lost their jobs.

Increasingly, we find ourselves coaching physicians to recognize staff are not shareholders in the business and do not get a vote on what is best for the business side of the practice. This orthopedic surgeon’s mistaken sense of loyalty to the staff resulted in all of them having to seek other jobs, which was not easy given their outdated skill sets. All of them had, in our assessment, below average reimbursement cycle and technology abilities.

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Arthroscopy Coding for Major Joint – Shoulder
Arthroscopy Coding for Major Joints – Shoulder

AAOS Now – March 2018
By: Michael R. Marks, MD, MBA

An accurate understanding of coding rules increases likelihood of receiving appropriate payment
Correctly reporting and billing for arthroscopy services is often confusing.

Last month, AAOS Now reviewed the knee arthroscopy codes and outlined the appropriate use of modifiers. This month, the topic is coding for shoulder and hip arthroscopic procedures.

Arthroscopic shoulder procedures
The traditional coding rule about the shoulder is to consider the joint as one compartment. Due to continuous efforts by orthopaedic societies, a two-compartment (intra- and extra-articular) viewpoint is gaining acceptance. As a result, a few coding rules have changed. Intra-articular structures include the labrum, the long head of the biceps, a Bankart lesion, and the humeral and glenoid articular surfaces. Extra-articular structures include the rotator cuff (RC), the distal clavicle, and the subacromial space.

In 2017, the Centers for Medicare & Medicaid Services (CMS) made a significant change to the extensive débridement code (29823). There are now three situations in which this code can be billed if the extensive débridement portion of the
procedure is performed in a separate area of the shoulder joint. This is similar to coding for the knee, which also has distinct anatomic compartments. The applicable codes are:

Telehealth: A New Frontier for Care Delivery
The Journal of Medical Practice Management – March/April 2018
By: Betty A. Hovey, CCS-P, CPC, CPMA, CPCD

One only needs to look at recent weather-related tragedies to see the impact of telehealth. Victims of hurricanes Harvey and Irma who had no way of getting to a clinic or hospital were able to be seen by physicians remotely. Telehealth providers such as Doctor on Demand, LiveHealth Online, EpicMD, and Nemours offered telehealth visits at no charge to the patients affected by the hurricanes in Texas and Florida. Florida Hospital offered free telehealth care, and nearly 3000 people took advantage of the services in a three-day period.’ The use of telehealth allowed for patients affected by natural disasters to be able to get medical care that they might have otherwise not been able to receive. This article discusses the
basics of telehealth, how it is being used in practices, and the coding, billing, and reimbursement issues related to getting paid to deliver it.


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Betty A. Hovey

Risks Associated with Critical Care Coding
Risks Associated with Critical Care Coding
ICD10 Monitor – January 2018
by Deborah Grider, CPC, COC, CPC-I, CPC-P, CPMA, CEMC, CCS-P, CDIP

Questions abound when reporting critical care services.

Reporting Adult Critical care can be complicated. It is not only the coding but the rules and that go along with critical care. Many questions come up when reporting critical care services. You would think it would be fairly straightforward since there are only two codes for adult critical care, 99291 for the first 30-74 minutes and 99292 for each additional 30 minutes in a calendar date. But questions always arise when a practitioner is performing critical care.

Supporting Medical Necessity for Critical Care

According to CPT® 2017: “Critical care is the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition. Critical care involves high complexity decision
making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.”

According to CMS and other payers, critical care must be medically necessary and is a service as service that encompass both treatment of “vital organ failure” and “prevention of further life-threatening deterioration of the patient’s condition”.

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Arthroscopy Coding for Major Joints – Knee

Michael R. Marks, MD, MBA

Arthroscopy Coding for Major Joints – Knee

AAOS Now – February 2018

By: Michael R. Marks, MD, MBA

When the American Medical Association (AMA) published the first edition of Current Procedural Terminology (CPT) to
standardize surgical procedure terminology and reporting, modern arthroscopy was in its infancy and no CPT code described it. As the number of arthroscopies for knee, shoulder, and hip conditions has exploded during the past few decades, CPT has attempted to address the reporting needs of these procedures. However, the constant clinical and technological advances, and the fact that CPT is only updated annually, have resulted in codes that lag behind common techniques. This scenario, in turn, has generated a good deal of confusion among surgeons and coders about how to correctly report and bill for these services.

The next CPT code changes to arthroscopic codes are scheduled for January 2019. To ensure correct coding until then, AAOS Now will present essentials for coding the most common arthroscopy codes. This month focuses on the knee; subsequent issues will feature shoulder and hip codes.

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Put Your Best Face (and Breasts and Body) Forward How to Showcase Your Surgical Results with Clinical Photography
Put Your Best Face (and Breasts and Body) Forward

How to Showcase Your Surgical Results with Clinical Photography

Aesthetic Society News – Winter 2018

by Amy Boyer, MBA

Every plastic surgeon knows that photography is an essential part of a cosmetic surgery practice. Early in practice you probably created a photo consent form and instructed your staff to get before-and-after surgery photos of every patient. You may have purchased special photo storage software, and at some point someone assembled the best photos to put on the practice website and in a book to be viewed in the office.

You did these things, because you understand that photos are a powerful tool for showing prospective patients the realistic results one can anticipate in the care of your skilled hands. In a survey by RxPhoto, 42.9% of consumers said that the photo gallery is the first page they visit on a practice’s website. Additionally, they serve as an important component of the medical record, documenting the surgical changes and providing a defense against allegations of improper or inadequate surgery.

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The physician’s role in the revenue cycle is important for optimizing charge capture in independent and employment settings. Understanding key acronyms related to code sets and reimbursement guidelines is important to an organization’s bottom line and future physician compensation.

This article explains five coding acronyms that physicians must understand, how they differ and why each is important.


CPT is a code set used in health care billing to describe both professional and diagnostic services. CPT codes are typically the foundation of insurance company reimbursement for physician services, and both private practices and hospitals
are reimbursed at either government-assigned allowable rates or payer-contracted rates. Thus, correct CPT reporting is essential for revenue optimization. The frequency of CPT reporting may impact physician compensation, as many employed physicians are credited for work relative value units (RVUs) that are linked to the CPT codes billed.

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Have You Heard the Latest Medical Liability Risk?

Michael R. Marks, MD, MBA

Have You Heard the Latest Medical Liability Risk?
AAOS Now – January 2018
By: Michael R. Marks, MD, MBA and Daniel R. Schlatterer, DO, MS

Court rules that surgeons must personally deliver informed consent
On June 20, 2017, the Commonwealth of Pennsylvania Supreme Court handed down a 4–3 decision that has the potential to rock the world of medical liability. The justices ruled that surgeons, in order to obtain informed consent, have the duty
to provide their patients with information about the risks, benefits, and alternatives of a particular procedure. Furthermore, surgeons must deliver that information personally.

Who is responsible?
In the underlying case, the patient filed a lawsuit alleging that all risks of a procedure were not fully discussed, which lead to discovery of the consent process. The Pennsylvania MCARE (Medical Care Availability and Reduction of Error) Act requires that physicians obtain informed consent and that certain information must be conveyed to patients to inform their consent. Utilizing Pennsylvania common law, a majority of the justices declared that the duty to obtain informed consent rests with the physician performing a procedure and not the hospital where it will be performed.