Frequently Asked Questions – Pain Management In Orthopaedic Practices

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.

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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).
CPT 2017 for Foot and Toes

Michael R. Marks MD, MBA

AAOS Now – January 2017
by Michael R. Marks, MD, MBA

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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If a constant stream of denials for hip arthroscopy procedures frustrates you, know that you are not alone. These denials are a common source of angst for physicians. The good news is, if you know how to avoid common coding pitfalls, document correctly, and follow payer medical policies, most of these denials will disappear.

The key is having proper documentation, prior to submitting the claim.

Hip Arthroscopy from a Coding Context
This minimally invasive hip surgery is still relatively new. Although the number of Current Procedural Terminology (CPT) codes is expanding, carrier policies have not quite caught up with the orthopaedic community’s acceptance.
The end of the year is a great time for physicians to review practice operations and policies and assess what’s being done well, what can be improved, and where priorities for next year lie. Reducing overhead and improving collections are no doubt high on that list. But don’t overlook the importance of managing risks – here are five that we find, all too often, are unaddressed in practices.
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.
Don’t Be Intimidated by ICD-10-CM Changes

Margaret Maley, BSN, MS

Don’t Be Intimidated by ICD-10-CM Changes – October 2016
by Margaret M. Maley, BSN, MS

A systematic look at the code update in orthopaedics

The 2,000 new ICD-10-CM (International Classification of Diseases, 10th edition, Clinical Modification) codes that go into effect Oct. 1, 2016, shouldn’t send you into a panic. The changes, when analyzed and approached systematically, are not overwhelming.

This article addresses changes in the musculoskeletal and injury chapters that affect orthopaedics. It does not cover editorial changes, additional punctuation, and codes not typically used by orthopaedic surgeons. Keep this article handy while examining the entire list of code changes in these two chapters. The online version of this article links to the 2017 changes. Choose the option “2017 Addendum,” then “tabular addenda.”
Gout
The “excludes 1” note for the M1A–Chronic Gout and the M10–Gout code categories has been eliminated. The “excludes 1” note indicated that the two listed codes should never be reported together and prevented the reporting of acute and chronic gout concurrently. These categories now have an “excludes 2” note, so the two codes can be used together if both conditions exist at the time.

Spine Practices May Lose Money When They Do Not Bill for Consults

Your Instructor: Kim Pollock, RN, MBA, CPC, CMDP
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.
**Are CMS and Other Payers Requiring –X{EPSU} Modifiers?**

Sarah Wiskerchen  
MBA, CPC

**Commonly Asked Coding Questions – September 2016**  
*by Sarah Wiskerchen, MBA, CPC*

**Q:** Are the Centers for Medicare & Medicaid Services (CMS) and other payers requiring use of –X{EPSU} modifiers?

**A:** Although the four –X{EPSU} modifiers were initiated by CMS, they have also been part of the Common Procedural Terminology (CPT) manual since 2015. These four modifiers—XE, XS, XP, and XU—are used in lieu of modifier 59. The modifiers are commonly called –X{EPSU} modifiers for separate Encounter, Structure, Practitioner, and Unusual non-overlapping service referenced in the EPSU acronym.

The latest CMS directives about using the –X{EPSU} modifiers were issued last year (2015). According to MedLearn Matters (Jan. 1, 2015), SE1503, providers could continue to use modifier 59 after Jan. 1, 2015, “in any instance in which it was correctly used prior to Jan. 1, 2015.” CMS also promised additional guidance and education on the appropriate use of the new –X{EPSU} modifiers.

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Why Malpractice Insurance Is Not Enough

Today’s orthopaedic practices are at a crossroads. Many face possible mergers or acquisitions and potential relationships with hospital systems and third-party payers. As the healthcare landscape shifts, so too does a practice’s professional liability exposures. Recently, I spoke with David Burke, director of Smith Brothers Insurance Healthcare Division, to find out what orthopaedic surgeons can do to protect themselves and their practices.

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