Telehealth at a Tipping Point

Telehealth at a Tipping Point – September 2017
By: Betty A. Hovey, CCS-P, CPC, CPMA, CPCS, and Cheryl Toth, MBA

What’s a service orthopaedic practices can offer that is popular with patients, reimbursed by most payers, not too expensive to implement, and deliverable in all 50 states?

Telehealth: Although it’s obviously not suitable for every type of patient encounter, the value telehealth confers to patients, practices, and payers has pushed adoption to the tipping point. These services also allow practices to differentiate themselves.

Why consider telehealth?
According to the American Telemedicine Association (ATA), telehealth has four primary benefits, as follows:

1. Improved access
2. Reduced costs
3. Improved quality/safety
4. Improved patient satisfaction

Indeed, a 2015 Harris Poll found that 64 percent of patients were willing to participate in telehealth visits because of convenience. The ATA says more than 15 million Americans received at least some medical care remotely in 2015, and it expects those numbers to grow by 30 percent in 2017.

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Top 10 HIPAA Mistakes for Practices to Avoid

Top 10 HIPAA Mistakes for Practices to Avoid – September 2017
By: Michael R. Marks, MD, MBA, and Michael Sacopulos, JD

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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Michael R. Marks, MD, MBA

Michael Sacopulos, JD
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
Got a Good Governance Agreement? Use This 12-Point Checklist to Find Out

Karen Zupko, President

Healio Orthopedics Today – August 2017
by Karen Zupko

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.

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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
Billing and Collections Staff Knowledge Assessment Tool for Orthopaedics

Message to the manager who may use this assessment tool:
All or portions of the following questions can be used for
interviewing/assessing candidates for open positions in various reimbursement related functions in the practice and with existing employees to assess their understanding of topics. If used for existing employees important to stress that it is a knowledge assessment tool to determine where more training or better position placement is needed, not a “test.”

Download Form

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**Medicare Sharpens Focus on the Global Surgical Package**

*Margaret Maley, BSN, MS*

**Medicare Sharpens Focus on the Global Surgical Package – June 2017**

by Margaret M. Maley, BSN, MS

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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Stay Current with Spine Procedural Coding

AAPC News – May 2017
by Kim Pollock, RN, MBA, CPC, CMSP

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
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.
2017 Medicare Guidelines for Imaging

Margaret Maley, BSN, MS

2017 Medicare Guidelines for Imaging – March 2017
by Margaret M. Maley, BSN, MS

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).