Six Steps for Conducting an Internal Evaluation & Management Audit

Sarah Wiskerchen, MBA, CPC

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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

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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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Six Steps Ways to Build the Practice ‘Brain Bank’

Cheryl Toth, MBA

Six Steps Ways to Build the Practice ‘Brain Bank’
Healio Orthopedics • Orthopedics Today – September 2017
by Cheryl Toth, MBA

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;

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.
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

Cheryl Toth, MBA
Learn the Latest in Otorhinolaryngology Coding

AAPC News – March 2017
by Kim Pollock, RN, MBA, CPC, CMDP

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

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

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)

Read Full Article
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.
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.
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.