ARE YOU MAKING BILLING MISTAKES IN YOUR ORTHOPEDIC PRACTICE?

25% of lost medical practice income is due to improper billing[1]

Most common general billing errors:

1. Not verifying a patient's insurance coverage
2. Entering incorrect provider information
3. Using incorrect patient data
4. Submitting incorrect information for the insurance provider
5. Inputting mismatched treatment and diagnostic codes
6. Forgetting to input codes for services performed
7. Under-coding
8. Duplicate billing
9. Provider(s) not credentialed at time of service
10. Missing (required) supplemental attachments
11. Providing incomplete documentation for services provided
12. Having problems related to general knowledge and use of modifier
13. Using insufficient ICD-10 codes

Biggest orthopedic billing hurdle is getting the right code

- Select your codes based on type of fracture, including the Gustilo classification system, laterality, and episode of care, along with other factors
- Provide proper documentation that supports the new codes
- Make sure you understand the meaning of the additional seventh character extensions for fractures
- Stay on top of the individual payer requirements for workers' compensation cases

Most common orthopedic billing errors:

Evaluation of Management

Use of "modifier 24"

- Claims billed without "modifier 24" can add 60–120 days to resolution

Overuse of high-level E&M without proper documentation

- This can cause mandatory audits and claim denials

Sharing misinformation on consult codes

- Some commercial payers still pay for consult codes, although Medicare does not

Not obtaining precertification/prior authorization/ referrals

Invalid (or lack of) authorization for services, such as:

- Fracture care in-office
- Viscosupplement-ation (Supartz J7321, Orthovisc J7324, SYNVISC® and Synvisc-ONE® J7325)
- Surgery (diagnosis and CPT® codes MUST be exact.
- Durable Medical Equipment (DME)
- Physical/ Occupational therapy

To avoid problems, Orthopedic staff must be trained regularly to determine which payers and services require authorization

Physical Therapy

Improper usage of Medicare G codes

Improper use of KX modifier for Medicare physical therapy cap

DME

Not following rules

- Must be billed with place of service code
- Registration and A/R staff must send DME claims for Medicare to one of four DME MAC jurisdictions based on the patient's ZIP code
- Billing claims without the following modifiers, when applicable: KX, RT, LT, NU, RR, UE

Advance Beneficiary Notices (Medicare)

Valid Advance Beneficiary Notices (ABN) must be on file when billing for services that are not expected to be covered

Modifier GA— indicates that a valid ABN is on file

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[1] Medical Group Management Association. Accessed Sept. 18, 2018, https://www.mgma.com/data.

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