AAPC
CUTTING EDGE
Healthcare Business Monthly

www.aapc.com
June 2013

2012 Chapters of the Year Excellence In the Heartland

Minneapolis, Minn., and
St. Louis West, Mo. Chapters

5th Annual Auditing Conference 2013

December 9-10, 2013 **Cobb Galleria Centre** in Atlanta, Georgia

Features of the NAMAS 5th Annual Auditing Conference

- The ONLY National Auditing-Specific Conference
- Expert Panel of speakers including Attorney Robert Liles, Shannon DeConda, Sean Weiss and many others (see agenda for full faculty)
- Preconference hands-on workshop Sunday December 8, 2013
- CPMA® course will be offered December 7th and 8th, 2013
- NEW for 2013 – Practice Management track available with the CEUs you need!
- See our website for full agenda with listing of all speakers and topics being offered

Earn Up to 20 CEUs by Attending Preconference and Conference!

Conference Topics

Medical Necessity • Infusion • Ortho/PT and Spine • Psychology
Critical Care/Trauma • Cardiology • General E&M – Hands-on session • Panel discussion each day

PLEASE JOIN US FOR A NATIONAL CONFERENCE BUILT EXCLUSIVELY FOR AUDITORS!

Early Bird Special:
First 100 people who sign up will receive a FREE TICKET to Georgia Aquarium and dinner with NAMAS!

REGISTER NOW!

HENRY SCHEIN® MEDICAL

www.NAMAS-Auditing.com | 877-418-5564

[Coding/Billing]

[Practice Management]

[Auditing/Compliance]

AAPC CUTTING EDGE
Healthcare Business Monthly
June 2013

[contents]

In Every Issue

Special Features

Education

Coming Up

- Insurer Relative Value
- Psychiatric Services
- Telehealth
- Revenue Cycle
- Medicare Consults

Features

On the Cover: *Thank you, 2012 Chapter of the Year Award recipients, Minneapolis, Minn., and St. Louis West, Mo., for your dedication to charity, coding excellence, and upholding a higher standard. Cover design by Tina Smith.*

Serving 120,000 Members – Including You!

Be Green!

Why should you sign up to receive *AAPC Cutting Edge* in digital format?

Here are some great reasons:

- You will save a few trees.
- You won't have to wait for issues to come in the mail.
- You can read *AAPC Cutting Edge* on your computer, tablet, or other mobile device—anywhere, anytime.
- You will always know where your issues are.
- Digital issues take up a lot less room in your home or office than paper issues.

Go into your Profile on **www.aapc.com** and make the change!

advertising index

AAPC CUTTING EDGE
Healthcare Business Monthly

June 2013

Director of Publishing
Brad Ericson, MPC, CPC, COSC
brad.ericson@aapc.com

Managing Editor
John Verhovshek, MA, CPC
g.john.verhovshek@aapc.com

Editorial
Michelle A. Dick, BS
Renee Dustman, BS

Production
Tina M. Smith, AAS
Renee Dustman, BS

Advertising/Exhibiting Sales Manager
Jamie Zayach, BS
jamie.zayach@aapc.com

Address all inquires, contributions, and change of address notices to:

AAPC Cutting Edge
PO Box 704004
Salt Lake City, UT 84170
(800) 626-CODE (2633)

Volume 24 Number 6 June 1, 2013

AAPC Cutting Edge (ISSN: 2326-2575) is published monthly by AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208, for its paid members. Periodicals Postage Paid at Salt Lake City UT and at additional mailing office. POSTMASTER: Send address changes to: Cutting Edge c/o AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208.

AMA
AMERICAN MEDICAL ASSOCIATION

ANNOUNCING

THE NEW AND IMPROVED

AMA STORE

FAST
SIMPLE
FRIENDLY

AND BIG SAVINGS TO CELEBRATE IT!

The resources you trust. The experience you want.

Our new **amastore.com** site is redesigned and ready for you! Now it's easier than ever to get all the resources you need for the business of medicine, with great new features like:

- **Streamlined search:** Find what you need faster than ever
- **One-stop checkout:** Purchase everything from CPT® products to your AMA membership more efficiently
- **Simpler navigation:** Easily access the right products for you

Special savings for AAPC members

AAPC members receive free shipping and 20% off the following titles now through July 31, 2013.

- **CPT 2014 Professional** (EP888814)
- **ICD-9-CM 2014 Physician** (OP065114)
- **HCPCS 2014 Codebook** (OP231514)
- **CPT Changes 2014** (OP512914)

Use promo codes **AAPC20** and **SHIPPC** at checkout.

STREAMLINED SEARCH | ONE-STOP CHECKOUT | SIMPLER NAVIGATION | BOOKS + MORE

AMA|store

Together We Move Forward

When it comes to good versus bad, April was a turbulent month. Let's recap some of the events that transpired and focus on the positive and our future.

Tragedy Strikes Our Nation

On Monday, April 15, bombs went off at the finish line of the Boston Marathon. This senseless act of violence has been marked as a tragedy for Boston and our nation. Sadly, there is little that can be said that hasn't already been said to help heal the wounds of those directly affected by the bombings. Although our sincerest sentiments may sound cliché, it's important to us to say them: AAPC sends our thoughts and prayers to our members in Massachusetts and to all those in Boston, where the wounds are still healing.

Coders Gather in Orlando

That same week in April also brought a wonderful experience for coding professionals. It was the 2013 AAPC National Conference in Orlando, Fla. While there, I had the distinct privilege of officially accepting my new role as AAPC National Advisory Board (NAB) president. There is a special "feeling," or maybe a better word is "energy," that comes from being part of our national conferences. More goes on than just learning and planning; there is a magical camaraderie that happens when we come together and share stories.

I had an opportunity to spend a little time with former AAPC Chairman and CEO **Reed Pew** on the golf course. I thanked him for all of the help and encouragement he has given me over the years, and for the great work he has done to make AAPC the prestigious organization it is today. I also spent time with new AAPC President **Korb Matosich,** and I must say I was quite impressed with his knowledge and leadership. I look forward to working with him in the coming years. Both of these outstanding individuals speak volumes about the quality of our organization and where we are going.

Congratulations to Our Outstanding Members

There is no greater honor than to be recognized by colleagues and peers for your good work. In the last issue, we recognized our 2012 Coder of the Year, **Joan Benham, CPC, CPC-H, CPC-I**. Joan joined Baylor College of Medicine's Compliance Division over five years ago, after spending many years at the University of Texas Medical Branch in Galveston. As a teacher, a mentor, and a true team player, Joan exemplifies the best that is in all of us. Congratulations and thank you, Joan!

In this issue, starting on page 32, we recognize our 2012 Chapter or the Year Award recipients: Minneapolis, Minn., and St. Louis West, Mo. AAPC appreciates your hard work, dedication, charity work, and professionalism. Congratulations for all you do to help others, as well as the coding profession!

Embrace the Future and New Beginnings

No matter how the changes in our industry turn out, or how they affect us as individuals, the fact is we are all in it together. It's up to us to forge the pathways that will define our industry for years to come. At the ground level, we'll continue to plan for ICD-10 implementation and the AAPC ICD-10 proficiency exam. For providers, the Centers for Medicare & Medicaid Services (CMS) has instituted electronic prescribing, the Physician Quality Reporting System (PQRS), and electronic health record incentive programs, which hopefully will improve the quality of care. Over time, the onus, however, will be on providers to demonstrate proficiency in their usage. These are just some of the challenges that healthcare faces in 2013. There will be many more.

Lastly, this is my first letter to AAPC membership as the "official" new NAB president. I want to thank each of you for your support and hard work. I look forward to the next two years.

Take care,

David B. Dunn, MD, FACS, CIRCC, CCVTC, CPC-H, CCC, CCS, RCC
President, National Advisory Board

You Know Reimbursement

The business of healthcare requires proficient billers with skills to handle all aspects of the revenue cycle. Without expertise in the nuances of the requirements of payers, reimbursement may be compromised. The Certified Professional Biller (CPB™) exam is a comprehensive evaluation of a biller's proficiency in all aspects of the revenue cycle, including claims creation and submission, follow-up, accounts receivable, denials management, and appeals.

Now Available

CPB™

Certified Professional Biller

AAPC

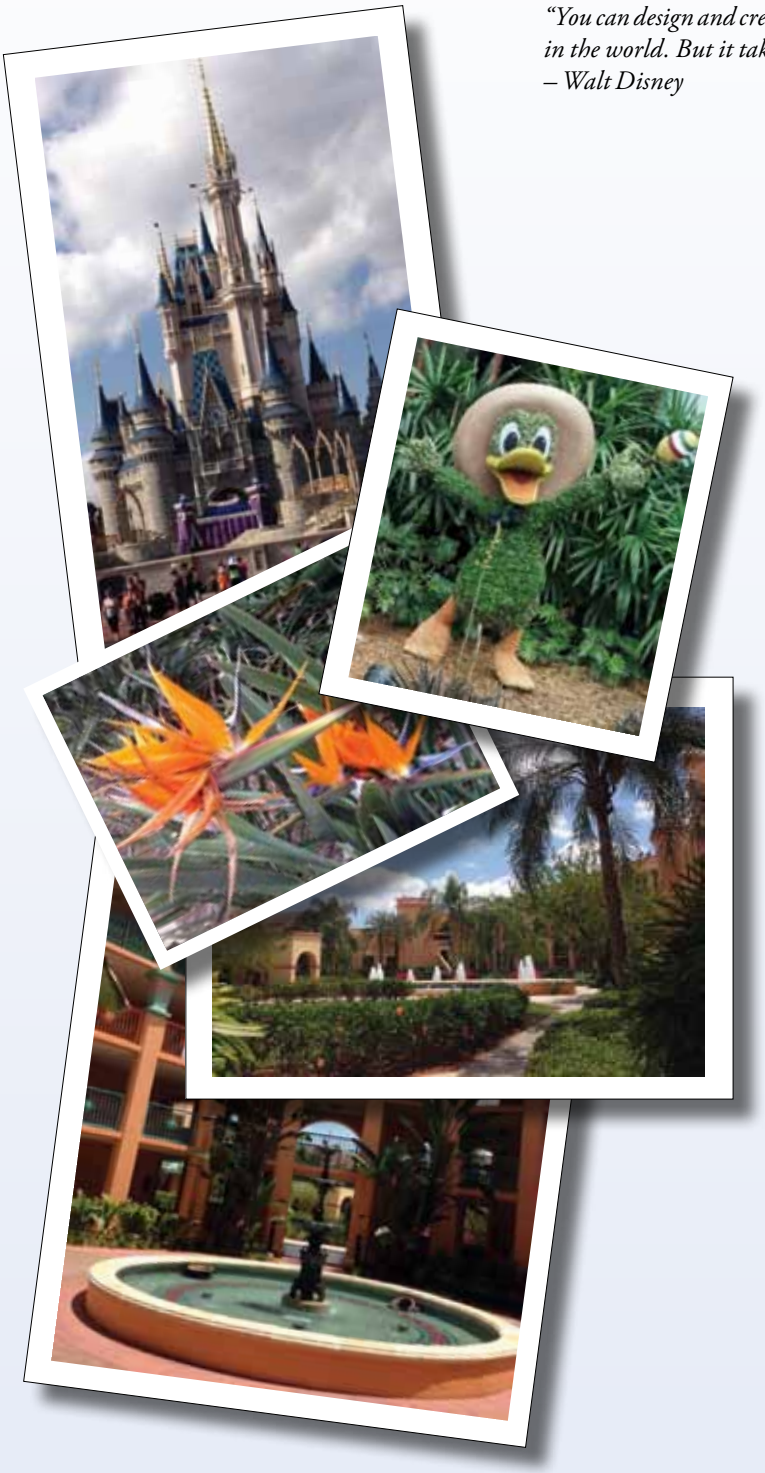
Learn more at:
www.aapc.com/medical-billing

By David Blackmer

Coders Feel Disney's Magic in Orlando

2013 AAPC National Conference: educational, unforgettable.

"You can design and create, and build the most wonderful place in the world. But it takes people to make the dream a reality."
– Walt Disney



Healthcare professionals gathered for the 2013 AAPC National Conference in Orlando, Fla., April 13-17, at "the most wonderful place in the world." This year's conference at Disney World's Coronado Springs Resort exceeded expectations and proved Walt Disney's wisdom to be true: When AAPC members come together, they turn dreams into reality. For three days the conference successfully balanced education with amusement thanks to talented, cheerful, and hardworking members and staff.

This year's conference offered the complete package: valuable education, extensive networking opportunities, industry-leading exhibitors, delicious gourmet food, and a whole lot of fun.

Preconference Excitement Fills the Air

Before most of the attendees arrived, AAPC hosted a few preconference events, including boot camps for Certified Professional Medical Auditor (CPMA®), Certified Interventional Radiology Cardiovascular Coder (CIRCC®), and Certified Professional Coder-Hospital Outpatient (CPC-H®), as well as a "Teach the Teacher" workshop for certified instructors. About 90 examinees spent Saturday morning and early afternoon testing to add new credentials to their repertoire, and a handful of them beta-tested the new Certified Professional Biller (CPB™) exam.

Sessions, Sessions, and More Sessions

With more than 70 educational sessions to choose from, attendees studied a variety of critical topics, including ICD-10 code set training, fraud avoidance, evaluation and management (E/M) coding and auditing for electronic health records, and common mistakes auditors investigate. Attendees had access to most presenter slides for preconference review and post-conference reference, but that didn't stop anyone from taking copious notes or asking relevant questions. All in all, attendees took advantage of the more than 20 possible continuing education units they could earn throughout the conference.

Other popular sessions included:

- "HCCs and Star Ratings – Coding and Revenue Integrity," presented by **James Taylor, MD, CPC**; **Victoria McKemy, MHA**; and **Nancy Hirschl, CCS**
- "Revenue Cycle Management in Coding," presented by **Yvonne D. Dailey, CPC, CPC-I**

... exhibitors distributed prizes like tablets, industry products, and gift certificates worth hundreds of dollars.

- "Preventive or Not Preventive? That is the Question!" presented by **Bradley Hart, CPC, COBGC**
- "Meaningful Use and ACOs 101," presented by **Stephen C. Spain, MD, CPC**, and **Angela C. Boynton, CPC, CPC-H, CPC-P, CPC-I**
- "Practice Performance Audits," presented by **Marsha S. Diamond, CPC, CPC-H**
- "Hot Buttons – Payers," presented by **Jonnie Massey, CPC, CPC-P, CPMA, CPC-I**

Anatomy Expo and ICD-10

As it has been in past years, the "Anatomy Expo" was an overwhelming success, with each session at full capacity. Physicians from a variety of specialties used anatomical models, devices, and videos to provide an insider's look at the human body. This information was particularly timely given the increased clinical specificity required for ICD-10-CM coding on the horizon. In fact, AAPC launched general ICD-10-CM code set training at conference with two full educational tracks, making the material available to as many attendees as possible. With the implementation deadline just over a year away, industry professionals enjoyed participating in these fundamental sessions that covered everything from coding guidelines to specific diseases and disorders of various bodily systems.

Healthcare Trends and Leadership

I heard a lot of praise for the general sessions, which offered valuable insights on ICD-10-CM, the healthcare industry as a whole, current legal trends and issues, and Disney leadership. AAPC's new president, **Korb Matosich, MBA**, explained the developing challenges in U.S. healthcare and encouraged more transparency and competition in medicine. Two general sessions covered ICD-10 issues, expounding on implementation strategies from different viewpoints and offering tips for dealing with clinical documentation difficulties. AAPC's Legal Advisory Board led a discussion on the most pressing legal concerns for medical practices and facilities facing increased financial scrutiny and regulations. The Disney senior facilitator described the Disney style of leadership through several charming anecdotes and videos.

AAPC President Korb Matosich speaks to members about healthcare challenges.

Feuds and Final Frontiers

Of course, there were some lighthearted general sessions, as well. The National Advisory Board (NAB) and the AAPC Chapter Association (AAPCCA) hosted "Regional Feud," a friendly competition to guess the most common answers to survey questions regarding the business side of medicine. The NAB also prepared a humorous and insightful sketch on "ICD-10: The Final Frontier" that William Shatner would be proud of.

AAPCCA also hosted their annual "Get to Know Your Local Chapter" event, which showcased the various local chapters represented at conference. This event always provides a great opportunity for chapter officers to learn from the successes of their fellow officers from around the country.

It's All About the Magic of Networking

Attendees took advantage of networking and creating lasting industry relationships with other healthcare professionals from around the world. Some made new friends with those from the same state, planning new local chapters and discussing area-specific challenges. Others chatted with old friends from as far away as South Africa or India, enjoying rich diversity and learning from different healthcare circumstances.

Diverse Exhibits and Vendors

Vendors in the Exhibit Hall offered samples and discounts on a variety of products, including code books, ICD-10 training, practice management tools, consulting services, industry publications, career-advancing education, and even fine jewelry. In addition to explaining product perks and offering special deals to conference attendees, exhibitors distributed prizes such as tablets, industry products, and gift certificates worth hundreds of dollars.

Gourmet Food

Coronado Springs Resort put out a fabulous spread each day that looked and smelled as good as it tasted. It was especially hard to stay

GTKYLC: Members hoot it up at the AAPCCA's "Get to Know Your Local Chapter" event.

I'm so blue: Donna Nugteren and Kathleen Burke show their true colors.

It's good to be green: Region 4 enjoys a delicious meal at the Coronado.

In the pink: Susan Ward and Erin Anderson

away from the dessert trays; the bite-sized cannolis and cannoncinis were a weakness for many. Attendees received complimentary refillable drink mugs, which were put to good use. With three days of all-you-can-drink soda, coffee, and tea, Disney World may now have a beverage shortage.

Honest Moment Filled with AAPC Pride

On a personal note: While fielding general questions at the central registration booth, I witnessed proof that AAPC members "uphold a higher standard." I overhead a very positive comment from an attendee who had just watched another woman come to the booth, ask about a lost purse, and rejoice when AAPC handed it to her with nothing missing. The attendee remarked how impressed she was with the integrity of AAPC members. In such a large resort with a couple thousand attendees gathered together, surrounded by countless other Disney guests, anybody could have taken and kept the purse. But AAPC members uphold a higher standard. One of you turned in that purse, and many others returned lost items, too. I am proud to be an AAPC member and associate with such kind and honest people.

What's Disney without Mickey?

Two Disney character appearances, Mickey Mouse and Princess Merida, served as a fun reminder of just how close we were to the theme parks. One of the conference perks was that attendees received a complimentary ticket to any one of the Disney theme parks. The bus schedule was organized for a Tuesday afternoon excursion to Magic Kingdom, Epcot, Disney's Hollywood Studios, or Disney's Animal Kingdom. This was just further proof that AAPC members can work hard and then play hard, finishing up the day with lightning-fast roller coasters, parades, and fireworks.

Onto the Next

With some help from Disney, AAPC members created healthcare magic at the 2013 AAPC National Conference in Orlando. I look forward to another fantastic national conference next year. How does Nashville sound to you? It's music to my ears!

David Blackmer is a marketing and public relations specialist at AAPC.

2013 Half-Year Webinar Subscription

Earn up to 42 CEUs with timely education from expert presenters-all from the comfort of your home or office. Purchase your AAPC Half-Year Coding/Billing Webinar Subscription for an unbeatable member price of just $395 (that's less than $19 per webinar) including:

- Earn up to 42 CEUs
- Access to 21 one-hour webinars (July - December 2013 schedule*)
- Access to live event + on-demand version
- Access to the presenter for online chat during the live event
- 2013 specialty updates for 5 specialties
- 2013 CPT® coding updates
- Access for the entire office*

**Includes one connection for an entire office to attend via a conference room.*
**Expires December 31, 2013.*

Unmatched CEU Value at

$395 for 21 Presentations

BONUS: Register in June to access additional events!

Date	Event	Date	Event
July 10	Urgent Care Coding: What You May Be Missing	Nov 13	A Closer Look at Molecular Pathology
July 17	2013 PQRS Measures and Codes	Nov 26	CPT 2014 Updates
July 31	2013 OIG Work Plan Update	Dec 3	Cardiology: Coding Updates for 2014 and Top Errors to Avoid
Aug 7	ICD-10 Musculoskeletal		
Aug 14	Gray Areas of E/M and Where to Find the Answers	Dec 4	E/M: Coding Updates for 2014 and Top Errors to Avoid
Aug 21	Specialized DME Coding		
Aug 28	The Lab Maze: Navigating Basic	Dec 5	General Surgery: Coding Updates for 2014 and Top Errors to Avoid
Sept 4	Coding for Diabetes: Pregnancy and Beyond		
Sept 11	Coding with Modifiers: CPT, Medicare, and the Real World	Dec 10	Emergency Department: Coding Updates for 2014 and Top Errors to Avoid
Oct 2	The Relative Value File and CCI Edits: What Changes Affect Your Practice?	Dec 11	Anesthesia & Pain Management: Coding Updates for 2014 and Top Errors to Avoid
Oct 9	Interventional Radiology Coding	Dec 12	OBGYN: Coding Updates for 2014 and Top Errors to Avoid
Oct 30	Monstrous Medical Conditions		
Nov 6	HCC Coding and Documentation: A Doctor's View		

AAPC

Visit aapc.com/webinars | 800-626-2633 (CODE)

Provider Must Record HPI

I read with interest "Ensure Documentation Supports Reimbursement" in April's *AAPC Cutting Edge*. In regard to the sample auditing compliance plan, in the History section (page 49), the second item states that the history of present illness (HPI) can be recorded by the ancillary staff or by the patient. In my opinion, this is not an accurate statement. If you ask anyone of us who audit/educate for a living, the HPI must come from the provider (e.g., physician, NP, or PA), not from ancillary staff or the patient. With the recovery audit contractors (RACs), zone program integrity contractors (ZPICs), Comprehensive Error Rate Testing (CERT) program, and Medicare itself zooming in, we are not taking a chance.

Barbara A. Love CPC, CPC-H

You are correct: The provider of record—not ancillary staff and/or the patient—must record the HPI.

Per both the *1995* and *1997 Documentation Guidelines for Evaluation and Management Services*:

> "The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others."

Nowhere do the guidelines specifically prohibit staff and/or the patient from recording the HPI; however, because HPI is not listed as an element that may be recorded by staff and/or the patient, it is inferred that HPI is not included. Individual payers (government and commercial) may issue guidance that explicitly requires the physician to record the HPI.

AAPC Cutting Edge

HHS Adopts EFT/ ERA Operating Rules

A final rule published April 19 in the *Federal Register* by the U.S. Department of Health & Human Services (HHS) adopts operating rules for healthcare electronic funds transfers (EFT) and electronic remittance advice (ERA) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). No changes were made to the interim final rule with comment period (IFC), issued Aug. 10, 2012. HIPAA-covered entities have until Jan. 1, 2014 to be in compliance with the EFT and ERA Operating Rule Set, now in effect.

The operating rule set, authored by the Council for Affordable Quality Health Care Committee on Operating Rules for Information Exchange (CORE), can be viewed at www.caqh.org.

The Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) (835) Rule was adopted in the IFC.

Revised and updated versions of the "CORE-required Code Combinations for CORE-defined Business Scenarios" will not be adopted through regulation. Covered entities are responsible for complying with the latest version, available at www.caqh.org/Host/CORE/EFT-ERA/CORE-requiredCodeCombinationsv301Jan2013.xlsx.

AMA Releases 2013 CPT® Corrections

The American Medical Association's (AMA) *Errata and Technical Corrections CPT® 2013* was released on May 1. The most recent entry changes are:

Pathology and Laboratory 88189

The parenthetical note following 88189 has been revised to remove the reference to deleted codes 0279T, 0280T and to add 86152, 86153 in their place.

Diagnostic Radiology, Spine and Pelvis – Short and Medium 72040

Code 72040 is revised to include the exact number of views—"2 or 3 views"—to eliminate overlap in the coding structure.

Short Descriptor 35103

"Groin" was changed to "aorta" in the short descriptor for 35103. The descriptor is now *Repair artery rupture aorta*.

Medium Descriptor 3044F, 3074F

The medium descriptors for 3044F and 3074F have been revised to:

3044F Most recent hemoglobin A1C level < 7.0%

3074F Most recent systolic blood pressure > 130 mm hg

Medium Descriptor 3082F

The medium and short descriptors for code 3082F are now:

3082F KT/V <1.2 (clearance of urea (KT)/ volume (V))

3082F KT/V <1.2

Download the complete corrections document from the AMA website at www.ama-assn.org/resources/doc/cpt/cpt-corrections-errata.pdf.

CMS Proposes IPPS Payment Schedule

The Centers for Medicare & Medicaid Services (CMS) recently released its proposed 2014 Medicare payment schedule.

In the proposal are payment cuts to hospitals that treat a high number of uninsured individuals, and small rate increases for acute care and long-term care hospitals.

The overall payment schedule affects all acute care hospitals as follows:

- They have until June 25 to respond to the proposed rule.
- In 2014, payments for general acute care hospitals will rise by 0.8 percent.
- CMS estimates the 0.8 percent rise will increase total payments to acute care hospitals by $27 million.
- As compared to 2013, Medicare payments to long-term care hospitals would increase by 1.1 percent (about $62 million) in 2014.

For Medicare disproportionate share hospitals (DSH), who serve higher numbers of low-income patients, about a quarter of the payments will be untouched. Depending on the DSH's number of uninsured, the remaining three quarters of payments will fluctuate. This is predicted to reduce DSH payments by 0.9 percent overall.

You can read the more than 1,424 pages of proposed regulations scheduled to take effect Oct. 1, 2013 on the *Federal Register* website at: www.ofr.gov/OFRUpload/OFRData/2013-10234_PI.pdf.

Append JE for Dialysate Solution

CMS change request (CR) 8256 instructs end-stage renal disease (ESRD) facilities to append new modifier JE *Administered via dialysate* to claims where drugs and biologicals are administered through the dialysate. Reporting modifier JE will be effective for service dates starting July 1, 2013.

Dialysate is used as a compound with injectable drugs and biologicals for drug administration. All drugs and biologicals furnished to ESRD beneficiaries for ESRD treatment are paid under the ESRD Prospective Payment System (PPS) base rate regardless of the administration method.

CMS says the purpose of modifier JE is to prevent inappropriate application of modifier AY *Item or service furnished to an ESRD patient that is not for the treatment of ESRD* due to confusion of whether a drug or biological is considered ESRD-related when it's added to the dialysate.

Per *MLN Matters®* MM8256, CMS said:

> "ESRD facilities will continue to have the ability to append the AY modifier (Item or service furnished to an ESRD patient that is not for the treatment of ESRD) when the drug or biological is furnished **for reasons other than the treatment of ESRD** with the exception of those drugs that are considered to always be ESRD-related."

Read CR 8256 and MM8256 in their entirety at: www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R2688CP.html.

Quick Tip

Match the Date of Service with the Date of Test Interpretation

Q. What date of service (DOS) should we use to report physician review and interpretation of Holter monitors (CPT® 93227 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional*)? I've heard that we should use the date the test is initiated (e.g., when the monitor is placed), but also to use the date the physician reviews the information and signs off on his or her report.

A. Depending on your payer, the guidelines for assigning a DOS for 48-hour electroencephalogram (EEG) recording may have changed over time. In 2009, for example, the Centers for Medicare & Medicaid Services (CMS) issued Transmittal 1873 (Pub. 100-04 *Medicare Claims Processing Manual*, chapter 26, section 10.6.3, Date of Service (DOS) Instructions for the Interpretation and Technical Component of Diagnostic Tests), specifying that effective Jan. 4, 2010:

"The appropriate DOS for the professional component is the actual calendar date that the interpretation was performed. For example, if the test or technical component was performed on April 30th and the interpretation was read on May 2nd, the actual calendar date or DOS for the performance of the test is April 30th and the actual calendar date or DOS for the interpretation or read of the test is May 2nd."

The Association for Quality Imaging (AQI), among other groups, objected to this policy, saying that it created a situation where you'd have to report the technical and professional components of a global service on different days, which could negatively affect patient care and complicate automated billing (see: http://associationdatabase.com/aws/AQI/asset_manager/get_file/13820). CMS subsequently removed section 10.6.3 from the *Medicare Claims Processing Manual* and has not yet directly replaced it with new instruction.

Effective April 1, 2011, CMS did, however, issue an attachment to its policy regarding 48-hour EEG (http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/29584_13/L29584_CV016_CBG_040111.pdf), which stipulates:

"CPT codes for Holter monitoring services (CPT codes 93224-93227) are intended for up to 48 hours of continuous recording. For 48 hour monitoring codes (CPT 93224-93227):

a. The documentation in the progress notes must reflect medical necessity for the service.

b. These services may be reported globally with CPT code 93224. Use the date of physician review as the date of service (DOS).

c. When submitting claims for the recording only (CPT code 93225) or for the analysis with report only (CPT code 93226) use the date the service was performed as the DOS.

d. When submitting claims for physician review and interpretation (CPT code 93227) use the date the service was performed as the DOS."

Per this instruction, whether you are reporting the "global" service (including recording and storage, scanning analysis with report, and physician review and interpretation, 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional*) or the physician component only (93227), the proper DOS will be the day the physician performs the review and interpretation (rather than the day the monitor was placed).

Most other payers conform to similar guidelines (which are also generally accepted by physician organizations and specialty societies), but you may wish to survey your non-Medicare payers to be sure you are reporting the correct DOS.

A&P QUIZ

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Think You Know A&P? Let's See …

Feet are flexible structures of bones, joints, muscles, and soft tissues. There are three basic sections to foot anatomy:

- The forefoot contains the phalanges and the metatarsals.
- The midfoot is a pyramid-like collection of bones that form the arches of the feet. These include the three cuneiform bones, the cuboid bone, and the navicular bone.

By Kathy Philp, CPC

Effective Hypertension Documentation Is in the Detail

Medical records documentation tells the relevant story of a patient in a way that even a provider who has never met the patient can understand. That level of detail may sound like a lot of work, but if the provider documents well on the initial visit, documenting subsequent visits is easier. Teaching providers how to be more specific in their reporting is more important now than ever, due to the coming implementation of ICD-10-CM.

To assist in training providers, let's start with a frequently used diagnosis in practices: 401.9 *Hypertension*. In the ICD-9-CM codebook, there is a full page of potential hypertension codes from which to choose. ICD-10 offers even more code choices.

Within ICD-9-CM, there are five hypertensive categories that identify type:

401 Essential hypertension

402 Hypertensive heart disease

403 Hypertensive chronic renal disease

404 Hypertensive heart and chronic renal disease

405 Secondary hypertension

In ICD-10, the essential, benign, and malignant hypertensive codes are combined, as below:

I10 Essential (primary) hypertension — includes high blood pressure; hypertension (HTN) benign, malignant, and essential

I11 Hypertensive heart disease

I12 Hypertensive chronic kidney disease

I13 Hypertensive heart and chronic kidney disease

Documentation might be similar to the following for a patient with HTN:

- Chief complaint (CC): "Follow up for HTN."
- Assessment: "HTN; doing well on current meds." And the assessment may review each illness (HTN, heart failure, Cushing's) separately.
- History: "The patient has heart failure and Cushing's disease."

Coders and providers may look at each diagnosis separately, coding the below scenario without realizing there may be a more appropriate code to report the highest specificity.

Condition	ICD-9-CM	ICD-10-CM
Cushing's syndrome	255.0	E24.0 (series)
Heart failure	428.0	I50.9
Hypertension	401.9	I10-I11.0 (use additional code)

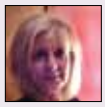
Review the documentation with the provider, and ask if the patient has hypertension due to either Cushing's syndrome and/or heart failure. If the answer is "yes" to one or both, the provider should document more explicitly (instead of separately documenting HTN, Cushing's disease, and heart failure in the HPI). For example:

The patient has HTN due to Cushing's disease [this could be one statement in the history].

Assessment:

1. Hypertension due to Cushing's disease (405.99 *Other unspecified secondary hypertension* or I15.2 *Hypertension secondary to endocrine disorders* in ICD-10)

2. Hypertension with heart failure (402.91 *Unspecified hypertensive heart disease with heart failure* or I11.0 *Hypertensive heart disease with heart failure* (use additional code) in ICD-10)



Kathy Philp, CPC, is practice manager with a large corporation in Edmond, Okla. A CPC® since 2004, she has 20 years of experience in medical billing, collections, reimbursement, and coding. Philp has expertise in coding for vascular, spine surgeries, pulmonary, cardiology, family practice, pediatric, sleep studies, and diagnostic imaging.

- The hindfoot forms the heel and ankle. The talus bone supports the tibia and fibula and forms the ankle. The heel bone is the largest bone in the foot.

Test yourself to find out where your A&P skills rank:

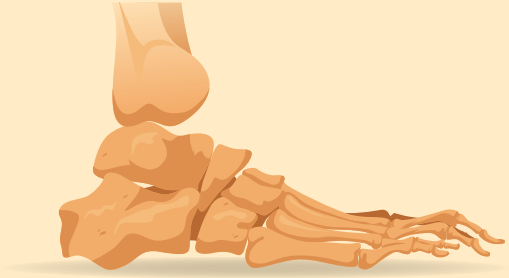
The heel bone is also called the:

A. Navicular

B. Phalanges

C. Calcaneus

D. Talus



Check your answer on page 65.

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC.

By Wendy Grant, CPC

Cheerleader, Mentor, Advisor, and Friend

Consider the role of member development officer.

An AAPC local chapter member development officer plays an important part in the success and livelihood of local chapters. He or she should be passionate about AAPC and its chapters (a cheerleader), interested in developing all members (a mentor), willing to assist with networking opportunities (an advisor), and always be a welcome face (a friend).

Cheerleader

The member development officer ensures all chapter meetings have time set aside to recognize and cheer on new members, newly certified members, and first-time attendees. These members should be acknowledged and appreciated for attending, made to feel comfortable at meetings, and encouraged to participate in meeting activities.

Mentor

Member development officers mentor all members during chapter meetings, help members with AAPC and local chapter questions, and encourage membership by providing information on the benefits of being a member.

Advisor

Member development officers act as advisors by proctoring at least one exam per year, monitoring and responding to the local chapter forum, and ensuring the chapter is moving forward in a positive and professional manner. They should network with Professional Medical Coding Curriculum (PMCC) instructors in the area.

Friend

Member development officers greet and welcome members and visitors at local chapter meetings. They are there to help, lend an ear, and encourage new networking relationships and chapter growth by inviting new faces to attend.

For more information on the role of member development officer, see the *AAPC Local Chapter Handbook,* chapter 5, section 8.

> The member development officer ensures all chapter meetings have time set aside to recognize and cheer on new members, newly certified members, and first-time attendees.

Development Officers: Take Advantage of New Member Lists

AAPC is now sending out a monthly listing of new members and newly certified members to chapter presidents and member development officers. Before the next meeting, the member development officer can easily reach out to members on this list. It provides the perfect opportunity for the member development officer to introduce him- or herself, to let new members know when and where the next meeting will be held, to ask if they are familiar with the location, and most importantly, to tell them that he or she looks forward to meeting them in person at the next local chapter meeting.

Wendy Grant, CPC, has been in the coding and billing industry for more than 30 years, with 22 years in clinic management. She is the accounts receivable manager for Health Management Physician Network, Western Division. Grant served on the AAPCCA board of directors between 2009 and 2012. She has been certified since 2002.

By Susan Edwards, CPC, CEDC

Officers: Plan a Multi-chapter Seminar or Conference

Hosting a local seminar or conference is a great way for chapters to offer members continuing education units (CEUs), but you don't have to go it alone. By combining your efforts with other chapters, you can share in the work and rewards that come from providing an excellent educational opportunity for members. Here are some pointers to ensure a successful chapter-run seminar or conference.

Share Responsibility

Form an organizing committee for the seminar or conference. Extend the opportunity to organize the event and serve on the committee to all chapter officers and members. Your pool of chapter volunteers will more than double in size when you combine efforts with other chapters, so there should be plenty of interest. Once you have a committee, determine a convenient location for all who may attend and share your speaker resources. This will provide a bigger pool of speakers, so consider expanding your seminar to a full day.

Advertise

Many members will travel for great education, so have your event posted on the local chapters' web pages early to encourage members to attend from farther distances. Send invitations to all chapters throughout your state and post the agenda on AAPC forums for all to see. Joint seminars and conferences allow for a great educational experience and huge networking advantages, so advertise it.

Remember: Get your event approved for CEUs and post it to all participating chapter forums.

Share Profits

You'll see positive results for all chapters and members who attend. After all the expenses are paid, as outlined in the *Local Chapter Handbook*, the remaining funds should be quickly and equally divided between the chapters who participate.

Survey for Suggestions

After the event, ask attendees to complete an evaluation or survey. Their feedback will show you what worked and what you should offer in future events. This information can help to make your next joint seminar an even bigger success.

By Lori-Lynne A. Webb, CPC, COBGC, CCS-P, CCP, CHDA

Facility

Factor in All Components of OB/GYN Hospitalist Coding

Coding relies on the details of these much-needed emergent care services.

Takeaways:

- OB/GYN hospitalists/laborists are physicians who support OB/GYN doctors in the hospital.
- Coding for an OB/GYN hospitalist requires an understanding of the specialty, as well as POS codes, time-based codes, E/M, ancillary services, and OB/GYN procedures.
- Within an OB/GYN hospitalist practice, E/M services are very time dependent. Knowing how to code accurately based on time is a necessity.

photo by iStockphoto/©Domenico Gelermo

Coding for an obstetrics/gynecology (OB/GYN) hospitalist requires an understanding of the OB/GYN specialty, as well as of place of service (POS) codes, time-based codes, evaluation and management (E/M), ancillary services, and OB/GYN procedures.

Get Time on Your Side

Within an OB/GYN hospitalist practice, E/M services are very time dependent. Due to the emergent nature of the practice, the physician may spend more time with the patient providing counseling and coordination of care, rather than providing an E/M service based on history, exam, and medical decision-making (MDM). CPT® allows for coding based on time if the physician or provider spends more than 50 percent of the face-to-face encounter in counseling and/or coordination of care. Knowing how to code accurately based on time is a necessity.

Documentation diligence for time-based coding is a factor in revenue and reimbursement for the provider. The most common scenario for an OB/GYN hospitalist practice is the outpatient or labor and delivery (L&D) hospital visit for a pregnant patient with a maternal or fetal problem that requires monitoring or extensive testing. These visits may require one or more hours spent on the floor or in direct face-to-face care and counseling with the patient, plus non-face-to-face time for ancillary testing (e.g., fetal non-stress tests or ultrasonography).

Scenario: Patient Sally Jones is 30 weeks pregnant. She arrived on the L&D unit stating that she "felt funny" after eating. She

states that she and one of her co-workers indulged in pizza and soda earlier this evening. She currently has gestational diabetes, managed only with diet. Patient reports she is uncertain what to eat because of its impact on her blood sugars. She is trying not to eat while she is working third shift at a local call center (overnights). She also complains of thirst, fatigue, and feeling tired all the time. She sleeps two to four hours at a time throughout the day. Patient has not noticed any decreased fetal movement or other problems with this pregnancy.

I performed a finger stick glucose test on the patient; her blood sugar reading was elevated at 183 (two hours post meal). I spent a total of 25 minutes face to face with Ms. Jones. Twenty minutes of that time was spent discussing the ramifications of gestational diabetes and non-compliance during pregnancy, which can include fatigue and thirst. The patient is having difficulty managing her diabetes at this time. I went over basic nutritional and dietary requirements regarding sugar, carbohydrate counting, and basic nutritional needs during pregnancy. I will also have patient undergo nutritional counseling with the diabetic educator. In addition, I also counseled the patient on future fetal non-stress testing and ultrasound testing, which we will coordinate with Sally's primary care OB/GYN, Dr. Jones, at the ABC123 clinic. Time in is 7:23 p.m.; time out is 7:48 p.m.

Coding: 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the pre-*

OB/GYN Hospitalists: The Up and Coming Subspecialty for Emergency Medicine

An OB/GYN hospitalist, or OB laborist, is a specialty OB/GYN physician who provides care in all areas of the hospital, including emergency, outpatient, inpatient, and observation areas for emergent and trauma patients. These specialists do not take the place of the patient's regular OB/GYN or family practice physician, but provide a much-needed service for emergent or trauma patients presenting outside of normal clinic hours. Private practice OB/GYN physicians have embraced this service, as hospitalists help to manage and care for the emergent patient in the interim, until the patient's regular physician arrives to assume care.

PHOTO(S) SHUTTERSTOCK.COM/ DANIELJOHN

In some hospital facilities, the OB hospitalist/laborist program is staffed 24/7/365. In other facilities, OB/GYN hospitalists may provide coverage for nights and weekends. They also help to pick up unassigned patients, and to provide coverage for private OBs and family medicine physicians who are in surgery or in clinic and unable to quickly arrive at the facility. In some practices OB/GYN hospitalists also function as maternal fetal medicine specialists.

As of September 2012, it is estimated that between 1,500 and 2,500 OB/GYN practitioners devote all or part of their time within a hospital labor and delivery department functioning as an OB/GYN hospitalist or laborist. The OB/GYN community has welcomed this sub-specialty as a part of the complete OB team for obstetric patients. In many private practices, when a patient is choosing a facility to delivery her baby, she is encouraged to meet the OB laborists as a part of the pregnancy tour experience.

OB/GYN hospitalists provide many different services within their scope of practice, including:

- Evaluate and manage emergent labor services ("I think I'm in labor," "I think my water broke," etc.)
- Measure cervix dilation
- Labor induction and management of the labor process
- Performing and/or order lab studies, fetal monitoring, and ultrasound
- Perform and assist vaginal, cesarean, and V-back deliveries
- Assess pain management needs
- Stabilize OB and GYN trauma patients (such as from a vehicle accident)
- Assess emergent GYN services such as pelvic pain, ovarian cysts, ovarian torsion, and heavy bleeding
- Provide interim OB/GYN care for patients with no local or assigned physician
- Provide surgical and procedure services such as cerclage, cephalic version, amniocentesis, and dilation and curettage services for miscarriage and fetal demise

This list shows only a small but important part of what hospitalists do.

Specific documentation criteria must be met to report the FNST ...

senting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

Dx: 648.83 *Abnormal glucose tolerance of mother, antepartum condition or complication*

POS Code: 22 *Outpatient hospital*

In this scenario, the OB/GYN hospitalist did not do a full exam, and took only a minimal history. The majority of this visit pertained to management of the gestational diabetes. The physician documented the total time spent, as well as time in and time out, as per CPT® requirements.

Stress Testing

Another crucial component to the practice is the fetal non-stress test (FNST). As part of the normal "scope of practice," fetal non-stress testing is an integral part of good patient care. The ultimate goal of antepartum fetal surveillance is to prevent fetal death. The FNST (CPT® 59025 *Fetal non-stress test*) is a non-invasive procedure that allows the OB/GYN hospitalist to evaluate the fetus and maternal status. When OB hospitalists perform this in addition to an E/M code, apply modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service* to the E/M code.

When coding the FNST, a coder needs to be clear if the service was performed as a "global" service, a physician interpretation-only service (modifier 26 *Professional component*), or a facility only/technical component service (modifier TC *Technical component* appended).

Specific documentation criteria must be met to report the FNST:

- **Clinical Indication:** e.g., decreased fetal movement, intrauterine growth restriction (IUGR), etc.
- **Interpretation:** e.g., fetal heart tones (FHT) show a baseline of 130 with 10 x10 accelerations and moderate variability. Reactive with no decelerations.
- **Time noted:** e.g., patient was monitored for "x" minutes over the course of her stay.
- **Signed/Authenticated:** e.g., Jose Hero, MD

Scenario: Ms. L is a 25-year-old gravida 5, para 3, female patient of Dr. Hero's at 33-4/7 weeks gestation, who presents to the L&D area at 8:05 p.m. complaining of uterine contractions. They are anywhere from four to 10 minutes apart and are mild to moderate. She denies any leaking fluid, ruptured membranes, or bleeding. She has had no problems with this pregnancy except that her blood pressure has been running somewhat high throughout her pregnancy, with systolics in the 140s on numerous occasions.

PHYSICAL EXAMINATION

VITAL SIGNS: Afebrile, vital signs stable.

GENERAL: The patient is a well-developed, well-nourished female in no acute distress.

ABDOMEN: Soft. Uterine contractions are present about every 4-6 minutes. Fetal heart tones show moderate variability, 15 x 15 accelerations and no decelerations, with a baseline of 145. Testing time = 45 minutes on the fetal monitor.

PELVIC: Cervix is very posterior, -2 station, 50% and tight 1 cm.

ASSESSMENT: False labor in a multiparous patient at 33-4/7 weeks gestation. Fetal status is reassuring.

Photo: Shutterstock/Oyindrilla Sen

PLAN: Patient was reassured regarding Braxton-Hicks/false labor. She will be calling Dr. Smith's office in the morning regarding possible pre-term labor care and somewhat elevated blood pressures. Patient was discharged from the unit at 9:39 pm.

Coding: 99213-25 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family* and 59025-26.

Dx: 644.03 *Threatened premature labor, antepartum*

POS Code: 22

In this scenario, you are billing for only the physician-based services (not the facility), so you'd report for the E/M service and only the professional portion of the FNST.

Obstetrical vs. Non-obstetrical Sonography

Another very important piece of an OB/GYN hospitalist practice is the evaluation using ultrasonography. The OB/GYN ultrasound has become a standard practice procedure during pregnancy. Ancillary ultrasound tests also provide a non-invasive avenue to diagnose, evaluate, and treat the emergent maternity patient. An ultrasound can quickly evaluate a fetus, placenta, or amniotic fluid levels within the abdomen. Providers may use ultrasound to assess fetal movement and growth, or detect an emergent condition or crisis affecting the fetus. An OB/GYN hospitalist practice performs the entire scope of OB ultrasound codes, and also performs traditional abdominal/pelvic ultrasound procedures.

CPT® describes obstetrical ultrasound with codes 76801-76828. The services include:

- Traditional OB ultrasound
- Fetal biophysical profile(s)
- Doppler velocimetry of the fetal umbilical and middle cerebral artery
- Echocardiography of the fetus

CPT® describes non-obstetrical ultrasound using codes 76830–76857. Such ultrasound guidance procedures are used with other procedures and surgical interventions, and require a permanently recorded image and a final written report.

Standby services can also be very confusing for coders and providers alike.

Example 1:

76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses*

HISTORY: A 29-year-old female, late care, MD request for size/date of pregnancy.

FINDINGS: A single live intrauterine gestation in the cephalic presentation, fetal heart rate is measured 147 beats per minute. Placenta is located posteriorly, grade 0 without previa. Cervical length is 4.2 cm. There is normal amniotic fluid index of 12.2 cm. There is a 4-chamber heart. There is spontaneous body/limb motion. The stomach, bladder, kidneys, cerebral ventricles, heel, spine, extremities, and umbilical cord are unremarkable.

BIOMETRIC DATA:

BPD = 7.77 cm = 31 weeks, 1 day

HC = 28.26 cm = 31 weeks, 1 day

AC = 26.63 cm = 30 weeks, 5 days

FL = 6.06 cm = 31 weeks, 4 days

Composite sonographic age is 30 weeks, 6 days plus or minus 17 days.

Estimated fetal weight is 3 pounds, 11 ounces plus or minus 10 ounces.

IMPRESSION: Single live intrauterine gestation without complications as described.

Example 2:

76830 *Ultrasound, transvaginal* to evaluate acute pelvic pain

HISTORY: Acute pelvic pain in a 22-year-old female.

FINDINGS: The right ovary measures 1.3 x 3.2 x 2.2 cm. There are several simple-appearing probable follicular cysts. There is no abnormal flow to suggest torsion on the right. Left ovary is enlarged, demonstrating a 6.0 x 3.0 x 3.2 cm complex cystic mass of uncertain etiology. This could represent a hemorrhagic cyst versus abscess. There is no evidence for left ovarian torsion. There is a small amount of fluid in the cul-de-sac, likely physiologic. Uterus measures 7.3 x 4.8 cm. The endometrial echo is normal at 6 mm.

IMPRESSION:

1. No evidence of torsion.
2. Large, complex cystic left ovarian mass as described. This could represent a large hemorrhagic cyst; however, an abscess/neoplasm cannot be excluded. Recommend either short interval follow-up versus laparoscopic evaluation given the large size and complex nature.

"Standby" for Better Coding

Another code used in the OB/GYN hospitalist practice is 99360 *Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG).* Standby services can also be very confusing for coders and providers alike.

CPT® defines a physician standby service as a service requested by another physician and involving prolonged physician attendance without direct (face-to-face) patient contact. The physician may not provide care or services to other patients during this period. A physician cannot use 99360 to report time spent proctoring another physician, or if the period of standby service ends with the performance of a procedure that is part of a surgical package performed by the physician who was on standby.

At this time, there are no official documentation requirements for 99360. This code should be billed in 30-minute increments. Coders may encounter a third-party payer that will not pay for 99360, but the Centers for Medicare & Medicaid Services (CMS) does have relative value units assigned to the code, and submission of the claim with good documentation should help you obtain payment when the provider is requested to be on standby.

To support standby services, in the event you are requested to provide documentation for payment, the following should be documented in the medical record:

- The request from the surgeon to the physician that they want on standby
- The reason standby is being requested (such as a high-risk OB cesarean delivery, urgent/trauma operative surgical session)
- The standby physician's time in and time out while on standby

For example, complete documentation might specify, "I (Dr. John Doe) was requested by Dr. Greg Smith to be on standby for the emergent, high-risk cesarean section to be performed on patient Jane Jones on March 1, 2013. I arrived at the OR at 10:57 a.m. and departed at 12:14 p.m."

In this scenario, you may report 99360 x 2 units for two complete 30-minute blocks of time. CPT® does not allow coding for a "partial unit" of standby if less than 30 minutes.

Lori-Lynne A. Webb, CPC, COBGC, CCS-P, CCP, CHDA, lives in Boise, Idaho. She provides coding, consultation, and education support for the Society of OB/GYN Hospitalists (Obgynhospitalist.com) and Saint Alphonsus Regional Medical Centers' OB/GYN, OB Hospitalists and Maternal Fetal Medicine specialty programs. She also writes her own "Lori-Lynne's coding coach" blog site.

By Julie-Leah J. Harding, CPC, RMC, PCA, CCP, SCP-ED, CDI

Learn VAD Management to Help Failing Coding

Understanding documentation is the key to accurate coding.

photo by Roy Perry © History of Medicine, Open Access

A ventricular assist device (VAD) partially or completely takes over the function of a failing heart. VADs are intended for short-time use for patients who have had cardiac surgery or a recent heart attack or who need a bridge to transplant. Long-term use may be required for patients with chronic congestive heart failure. VADs assist either the right ventricle (RVAD) or the left ventricle (LVAD), or both at once (BiVAD), depending on the patient's underlying heart disease. These devices have come a long way in a relatively short time. Medical coding has had to keep pace with technology.

For professional billing of VAD insertion or pump replacement, select from the following CPT® codes:

33975 *Insertion of ventricular assist device; extracorporeal, single ventricle*

33976 *Insertion of ventricular assist device; extracorporeal, biventricular*

33977 *Removal of ventricular assist device; extracorporeal, single ventricle*

33978 *Removal of ventricular assist device; extracorporeal, biventricular*

33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle*

33980 *Removal of ventricular assist device, implantable intracorporeal, single ventricle*

33981 *Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump*

33982 *Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass* [no global period]

33983 *Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass* [no global period]

Example No. 1

The patient has orthotopic heart transplant with insertion of 10 mm GORE-TEX® graft from the left superior vena cava to the recipient's right atrium, with removal of the BiVAD.

Report: 33978 for removal of the extracorporeal (outside the body), BiVAD.

Example No. 2

A thrombus in a Berlin heart LVAD occurs in a 21-year-old patient with dilated cardiomyopathy. The patient is transported to the operating room and placed on bypass. The pump head is changed to a 30 cc pump head, without complication.

Report: 33982 for replacement of intracorporeal VAD pump with bypass.

Example No. 3

A patient with dilated cardiomyopathy and end-stage left ventricular failure requires an emergent LVAD implantation.

If the VAD management documentation is too limited, report an E/M service only.

Report: 33975 for insertion of an extracorporeal VAD, single ventricle.

Interrogation and Programming

Patients with a previously implanted VAD require periodic interrogation of the device. In 2010, CPT® introduced a new code to report this management: 93750 *Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report*. This code includes the physician analysis, review, and report. It also includes device programming, if performed. It has been assigned no global days.

Code 93750 is NOT reported with any of the surgical implantation codes (33975, 33976, 33979, 33981-33983), but typically is reported with an evaluation and management (E/M) visit. VAD management is considered a diagnostic service, which must be performed in person and includes a face-to-face assessment of all device functions. Components that must be evaluated include:

- Device parameters (e.g., alarms, drivelines, clots, infection, overall assessment of augmenting cardiac output, and power surges)
- Device function (flow/volume status, septum status, and recovery)

All of the above must be stated in detail, either in its own procedure note (if management is part of the daily rounding) or in its own paragraph (separate from the rounding note, if performed during rounding). Adjustments may not be needed each day, but each entry must support assessing the potential need.

Example No. 4

8 y/o with DCM titin mutation with end-stage HF, FTT, NSVT, s/p HW LVAD. Pt noted that the side of the bag felt damp, but no h/o spilling on the controller or driveline. Driveline examined and clean, no tears, no fluid within line. With readjustment of driveline at lug into controller, alarm stopped, but asked to come back to hospital to clean out receptacle of driveline connector.

HW programmer arrived this afternoon to perform cleaning, which required disconnecting and stopping VAD x3 for total of 1 minute. IV access was acquired, in case entropic support would be necessary.

Baseline VSS: HR 90, MAY 58

AM meds were held.

Driveline cleaned and was found to have small debris in connector (unknown substance, sent for histopathology to determine what it is). Pt tolerated being disconnected well. Pt felt lightheaded and complained of mild headache and nausea. HR increased quickly to 140, Pt felt pressure in the chest and lungs that resolved instantaneously with starting the pump again at RPM 2440. Flows resumed to 3.5-4.2 L/min and power 3.2 watts.

Post procedure: Pt felt improved with no further headache. Observed for 2 hours post with no events. VAD settings: 2440 RPM; calculated CO: 3.2-4.5 L/min; power: 3.2 watts; alarm settings: low flow 2 L/min and high power 4 watts.

Report: A patient on VAD often has numerous issues being managed. One such scenario is where a patient remains on VAD but has failure to thrive along with acute or chronic congestive heart failure and is awaiting transplant. For the services associated with this case, you may bill the appropriate E/M code with modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service* and report 93750 with cardiomyopathy (425.4 *Other primary cardiomyopathies*) and VAD status (V43.21 *Organ or tissue replaced by other means, heart assist device*).

If the VAD management documentation is too limited, report an E/M service only. For example, you may have a patient who remains in the cardiac intensive care unit, intensive care unit, or possibly a step down to the telemetry unit, who continues to use the VAD device. If the patient has been an inpatient for some time, the note may simply state, "The VAD setting remains appropriate and unchanged." With such a limited capture, do not report 93750; instead, claim only the subsequent critical care or inpatient level of service.

Julie-Leah J. Harding, CPC, RMC, PCA, CCP, SCP-ED, CDI, is director of education at Medical Records Associates, LLC. She has 21 years of experience in coding, compliance, training, and auditing. Harding specializes in performing multi-discipline E/M, emergency department, and congenital cardiovascular surgical audits within the acute care and outpatient settings. She also trains and orientates providers on all documentation guidelines and compliance. Harding has expertise in implementing SNOMED CT® methodology and GEMS mapping.

By G.J. Verhovshek, MA, CPC

Remember the "Three Rs" for Payers Accepting Consults

Proper documentation is a must for reimbursement of 99241–99245, 99251–99255.

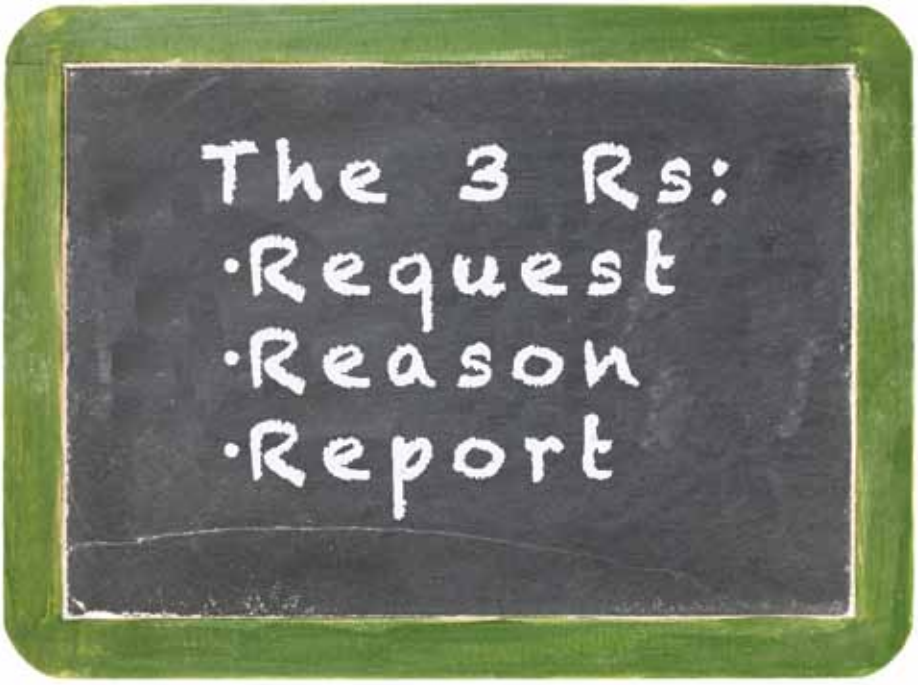
Takeaways:

- Private payers may reimburse consultation services provided they are supported by the "three Rs" of consult documentation: Request, Reason, and Report.
- Consults involve three individuals: a requesting provider, a consulting provider, and a patient.
- Consults require three of three key E/M components.

Medicare payers haven't accepted claims for either outpatient (99241-99245) or inpatient (99251-99255) consultations since Jan. 1, 2010. Private payers, however, may still pay for consultation services as long as those services are supported by the "three Rs" of consult documentation: Request, Reason, and Report.

First R: Request

Every consult must begin with a request. CPT® specifies, "The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source."



Because the consulting provider bills the service, it's in his or her best interest to document the request as part of the patient record. For example, a consulting physician might begin the record, "Ms. Jones is here today at the request of her primary care provider, Dr. Smith, for a consultation to evaluate condition X." Specify that the visit is "consult" (not, for instance, a "referral," which may signify to the payer a transfer of care request rather than a request for consultation). If possible, ask the requesting provider to put it in writing (email, fax, a note sent with the patient, etc.) and to make that part of the record, too. In the inpatient setting, the request may be part of the shared patient record.

Services provided solely at the request of a patient, family member, or non-clinical caregiver do not qualify as consultations. An appropriate source for a consult request can include physicians or other individuals who can act on the advice/information the consulting physician provides. Generally speaking, qualified non-physician practitioners (NPP) can request and provide consults (99241-99255) as long as the services are within their scope of practice, as defined by their state, credentialing body(ies), and facility. To be certain, consult your payers' guidelines for their rules on whether NPPs may provide and/or request consultations.

Second R: Reason

The requesting provider must also state a specific reason (i.e., patient complaint or condition) to justify the need for a consultation. For example, if the patient's primary care physician wants a specialist to evalu-

... perhaps most importantly, the consulting provider must render his or her opinion and return a written report of his findings and treatment suggestions to the requesting provider.

ate a patient due to a suspicious breast lump, she should state this reason explicitly in the request for consult.

Third R: Report

Lastly, and perhaps most importantly, the consulting provider must render his or her opinion and return a written report of his findings and treatment suggestions to the requesting provider. The entire reason for the service, after all, is so the consulting physician can give his opinion and advice to the requesting provider. Without a report back to the requesting provider, a consultation hasn't occurred.

Consults Require Three of Three Key Components

If a request, reason, and report are sufficiently documented, you may submit claims for consultation services to (non-Medicare) payers who accept them. Select 99241-99245 for consultations provided in the physician's office, or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency department (ED).

Select 99251-99255 for consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. An individual provider may report only one inpatient consult per inpatient stay. For follow-up visits by the same provider subsequent to a consultation, but during the same inpatient stay, report subsequent care codes (e.g., 99231-99233 *Subsequent hospital care* ...).

Both the outpatient and inpatient codes apply for new and established patients and both types of consultation services require you to meet all three key components (history, exam, and medical decision-making (MDM)) to report a given level of service. Practically speaking, the "lowest" of the three components always determines the level of service reported.

For example, a general surgeon is called to the ED to see a 55-year-old (non-Medicare) patient for assessment of abdominal distention, nausea, and vomiting. The request and reason are documented in the medical record. The surgeon renders an opinion and reports this to the requesting physician. The surgeon documents a detailed history (HPI = 4, ROS = 2-9 systems, and PFSH = 1) and detailed examination (2-7 organ systems and/or body areas), with MDM of moderate complexity (diagnosis = 2, data = 2, and risk = low; you must meet two of three). Because the service occurs in the outpatient setting, the proper coding is 99243 *Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity....*

Tip:

If requesting physicians do not consistently provide a written request and reason for a consult, consider using a standard "consult sheet" that the consulting physician can fax or email to the requesting physician's office. The requesting provider can fill in the necessary information and return it to the consulting physician. In doing this, the requesting provider also has a completed copy of the request and reason. This may sound like a lot of trouble, but lackluster documentation may mean the consulting physician won't get paid at all.

Beware of Transfer of Care

When a "consulting" provider assumes full care of a patient's problem, a referral or a transfer of care has occurred, and you should not report a consult service. Instead, the receiving physician should report a new or established patient visit, depending on the situation and setting (e.g., office or inpatient).

What Makes a Consult Unique?

CPT® defines a consultation as "a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for care of a specific condition or problem."

In other words, the service involves three individuals: a requesting provider, a consulting provider, and a patient.

The requesting provider asks the consulting provider to examine the patient and give his opinion on a patient's specified treatment and/or condition. The point of the service is that the consulting provider has some knowledge, training, or expertise the requesting provider does not have, making the consulting provider better able to evaluate the patient and recommend treatment for a particular condition or complaint. Generally, the consulting provider will be a specialist or subspecialist, or the requesting and consulting providers will be of different specialties/subspecialties.

The consulting provider may report a consultation code (for non-Medicare payers who accept consultation codes) even if he or she performs diagnostic testing, begins treatment, or—subsequent to completing the consultation service—accepts responsibility for the patient's care. What matters most is that the "three Rs" (Request, Reason, and Report) are properly documented.

photo by iStockphoto © adam36

Fourth R: Readability

Payers and auditors follow a simple rule: Documentation that can't be read is the same as no documentation at all. To support services billed, all documentation must be reasonably legible by someone other than the provider who wrote it. Electronic health records are helpful in this regard, as are scribing services for offices still wedded to pen and paper.

In a second example, the managing physician requests that a specialist provide a consultation for a hospital inpatient recovering from surgery and complaining of (unrelated) abdominal pain. The specialist meets with the patient and performs a full history and exam. She prepares a report of her findings and shares these with the requesting physician. When preparing the claim for a payer who recognizes consultation services, report an initial inpatient consult (e.g., 99254 *Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity*). If the same specialist provides additional services to the same patient during the same inpatient stay, report the subsequent services using the 99231-99233, as determined by the level of documentation.

Time Can Become the Determining Factor

If more than 50 percent of the consultation visit is spent in counseling or coordination of care, you may report the consultation using time as the primary component (rather than history, exam, and MDM). Note that the outpatient codes (99241-99245) include only face-to-face time with the patient; whereas, inpatient codes (99251-99255) include face-to-face time, as well as time spent on the hospital floor on the patient's behalf.

In an upcoming issue of *AAPC Cutting Edge*, we'll cover how to report consultation services for Medicare payers.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

By Brandi Tadlock, CPC, CPC-P, CPMA, CPCO

photo by iStockphoto © Bali86

Deliver Constructive Criticism the Thoughtful Way

Because nobody likes being wrong, you must be delicate and effective when pointing out error.

Every position in healthcare administration occasionally requires the ability to tactfully offer constructive criticism. Understanding when, where, and how to critique the work of your colleagues is critical to ensuring your message is received, without destroying rapport in the process. The next time you are faced with critiquing an employee's performance, keep the following tips in mind.

1. Check your facts.

Never tell someone they're wrong unless you're prepared to back up your opinion with facts (preferably using information from an authoritative source such as the Office of Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS), or CPT® guidelines). Make sure you have a firm understanding of the subject and don't be afraid to consult with someone more knowledgeable, if necessary. Telling someone he or she is wrong when you're the one who's incorrect is embarrassing, destroys your hard-earned credibility, and will make it more difficult for you to be taken seriously in the future.

2. Gain perspective on complex issues.

It's important to know what you don't know. If you don't have all of the facts about a situation before sounding the alarm, you might end up inadvertently "crying wolf." If a situation doesn't seem right to you, don't be afraid to speak up. Just make sure you ask questions first to ensure you have the full picture.

3. Remember the "Golden Rule."

How would you feel if you were on the receiving end of your criticism? It's important to mind your tone and your choice of words to avoid being perceived as bossy, condescending, or arrogant. Think about what you'll say before you say it and try to find the most tactful way to deliver your message.

If a situation doesn't seem right to you, don't be afraid to speak up. Just make sure you ask questions first to ensure you have the full picture.

4. Consider the best method for approaching the subject.

Some issues are best discussed in person and some are best handled via email. If you choose to address an issue in person, it's always best to do so in private to avoid publicly shaming the other person.

If you must discuss an issue via email, it's especially important to proofread your email. Avoid statements that could be taken the wrong way, as it's more difficult to ascertain tone in writing. If possible, have someone else review your email before sending it to make sure your message reads the way you intend it to sound.

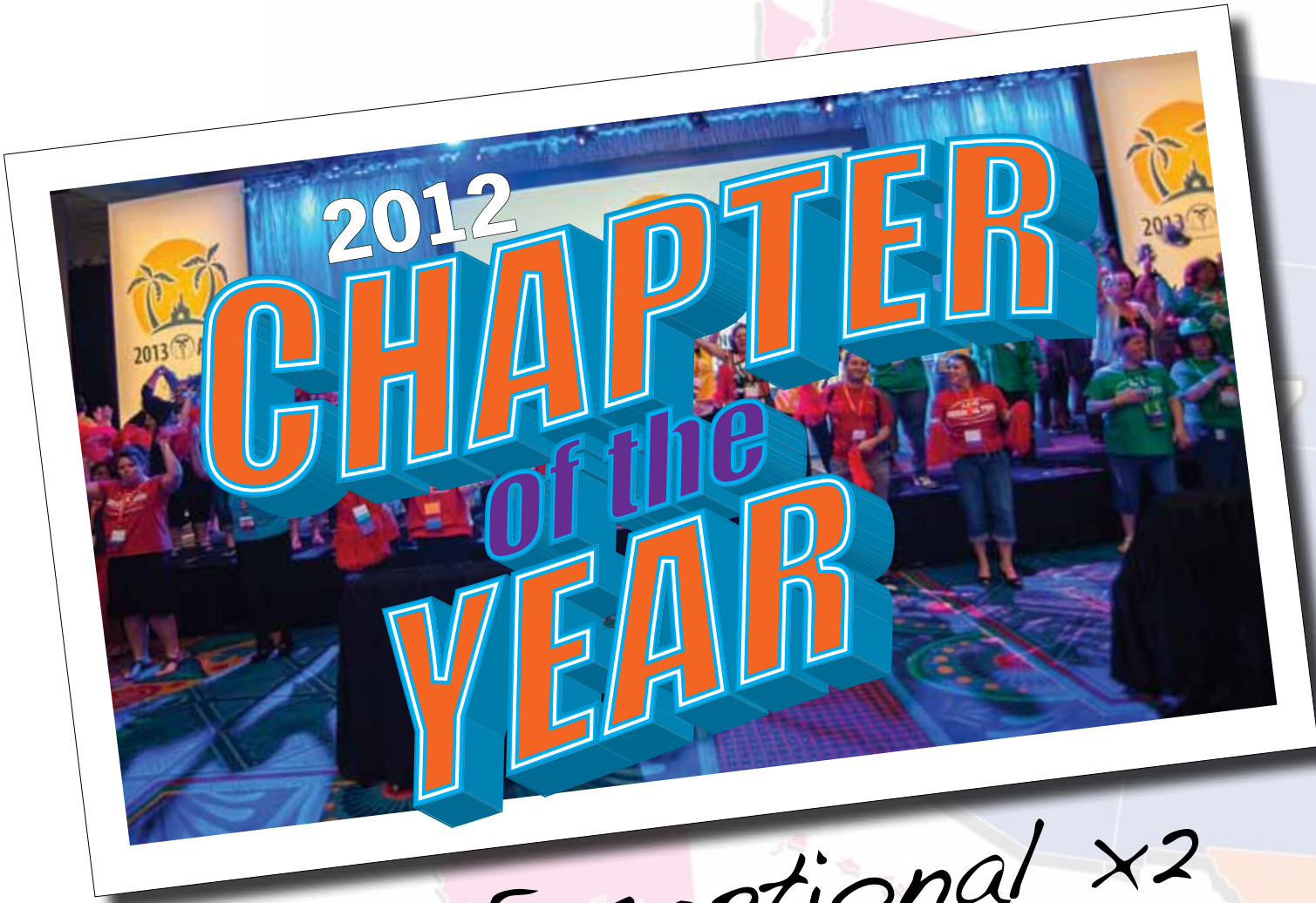
5. Have a solution prepared, but opt for a resolution.

It's important to offer solutions whenever you point out a problem, but keep in mind that other people may have their own ideas for solving the problem, which may be just as good as yours. Collaboration in problem-solving helps to build rapport, demonstrates that you recognize the other person's intelligence, and that you value his or her opinions.

Constructive criticism can be a difficult skill to master, but it's one that will greatly benefit you in every aspect of your career.

Brandi Tadlock, CPC, CPC-P, CPMA, CPCO, is a member of the Lubbock Lone Star Coders chapter. She's been in healthcare for five years, working as a coding and compliance analyst, a medical record auditor, and a reimbursement specialist.

By Michelle A. Dick



Exceptional x2

Minneapolis and **St. Louis West** make excitement, generosity, and strong leadership contagious.

2012 is unique in that AAPC selected two Chapters of the Year: Minneapolis, Minn., and St. Louis West, Mo. According to AAPC Director of Local Chapter Support **Marti Johnson**, "The reason we had two winners is because both chapters were pretty evenly yoked in going above and beyond for their members, more so than the other chapters." Both Minneapolis and St. Louis West met the basic requirements for qualifying, and then some.

To contend for the AAPC Chapter of the Year award, a chapter must:

- Hold at least four exams and six meetings where continuing education units (CEUs) are offered;
- Submit all chapter meeting minutes, Election Verification, Profit and Loss statements, and quarterly meeting reports on time;
- Display positive and professional attitudes as outlined in the "Local Chapter Code of Conduct";
- Go above and beyond for your chapter members and communities; and
- Be more than willing to help AAPC when contacted by AAPC for help or to accommodate.

To win the award, however, a chapter has to go above and beyond these basic requirements. Minneapolis and St. Louis West chapters took different routes to make them exceptional.

Minneapolis, Minnesota
Region 6

Award Ceremony at AAPC's 2013 National Conference in Orlando: Angela Jordan and Marti Johnson present Minneapolis chapter officers JoAnne Wolf and Pam Tienter with the 2012 Chapter of the Year award.

Minneapolis is a 450-member strong chapter. It's a diverse group representing several core credentials and over a dozen different specialty credentials. According to AAPC's Local Chapter Officer/Member Liaison **Emilie Nelson**, Minneapolis members accomplished great things in 2012. The chapter:

- Participated in planning and facilitating a state coding conference;
- Held additional exams and meetings to accommodate members;
- Held review classes to help their members prepare for the exam;
- Distributed survey forms at meetings to encourage members to comment and give ideas;
- Reviewed the "Local Chapter Code of Conduct" with members;
- Reviewed the "AAPC Code of Ethics" with their members;
- Went "green" by offering slides and presentations electronically instead of paper copies;
- Collected blankets and washcloths for Hennepin County Animal Shelter;
- Collected 124 pounds of pop tops for their local Ronald McDonald House;

ICD-10-CM
General Code Set Training

The most affordable methods for coders to prepare for ICD-10

Over the last few months we've heard from thousands of members preparing for ICD-10. The most common feedback has been to "make ICD-10 training more affordable and accessible". In response, we're re-launching general code set training to do both.

Our BOOT CAMPS now have added value. With ONLINE, we're lowering pricing -- dramatically. And LOCAL CHAPTERS can now put on their own ICD-10 events using our curriculum and trainers to create a boot camp experience at pricing rivaling online training.

Combined, we have the most affordable and accessible options for ICD-10 code set training anywhere.

- Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, CPEDC, CENTC
  Vice President, ICD-10 Training and Education

- ICD-10 format and structure
- Complete, in-depth ICD-10 guidelines
- Nuances of the new coding system
- Hands-on ICD-10 coding exercises
- Course manual for ICD-10-CM Code Set

Choose from three methods:

AAPC

Boot Camps | 16 CEUs

$595

2-day live training and interactive group environment in a city near you.

BONUSES:

- Includes online general code set training ($395 value)
- Includes ICD-10-CM code set book ($89.95 value)
- Includes ICD-10 Practice Assessment ($39.95)

REGISTRATION NOW OPEN!

Online | 16 CEUs

~~$395~~ **$295**

For a limited time

Online training at your own pace.

REGISTRATION OPENS JULY 2013!

Local Chapter | 16 CEUs

Pricing Varies

2-day live training and interactive group environment at a local chapter near you.

*** Only available with participating chapters**

REGISTRATION THROUGH LOCAL CHAPTER

Learn more at: **www.aapc.com/icd10**

First Row: JoAnne Wolf, Amy Conroy, Suzanne Taylor, Ruby O'Brochta-Woodward
Back Row: Pam Tienter, Helen Osterkamp, Lisa Sherman, Cindy Elliott, Kelly Moore. **Not pictured:** Louise Dowling

- Collected $781 for the Second Harvest food shelf; and
- Strived for an informal, open, and friendly atmosphere at every meeting.

The achievements of the Minneapolis chapter were led by a dedicated group of chapter officers who worked hard and volunteered countless hours to make their chapter shine. The officers in 2012 were:

- President: **JoAnne Wolf, RHIT, CPC, CEMC**
- Vice President: **Pam Tienter, CPC, CPC-P, CCS-P, CPC-I**
- Education Officer: **Lisa Sherman, CPC**
- Member Development Officer: **Kelly Jo Moore, CPC, CEMC**
- Secretary: **Cindy Elliott, MA , CPC**
- Treasurer: **Helen Osterkamp, CPC, CPC-P**

The astounding amount of charitable work Minneapolis chapter members achieved in 2012 was a major factor setting them apart from other chapters. When we asked then-President Wolf why she thought Minneapolis won the Chapter of the Year award, she attributed it to their generosity, and claimed **Louise Dowling, CPC**, was a driving force behind much of it. Dowling challenged members to collect for several charities and followed through with the collection and hand delivery of all donations.

Building Networking and Lasting Friendships

The charitable work wasn't the only thing that set this chapter apart from others in 2012, it was the networking and the friendships that were built. Wolf said that Minneapolis has "always strived at providing an informal, friendly, and warm atmosphere at meetings. I have formed life-long friendships with so many chapter members and I consider them to be a coding family. Of all the wonderful qualities of our chapter, it's this asset that I am most proud of."

Then-Member Development Officer Moore said, "I feel the same way as JoAnne about forming lifelong friends.

"Most importantly, it's the atmosphere of our chapter meetings that gets new members to keep coming back," Wolf said.

Strong Leaders Make Strong Chapters

Winning the Chapter of the Year award takes dedicated officers and the efforts of an entire chapter. Great leadership trickles down the ranks, strengthening and creating more strong leaders. 2012 President **JoAnne Wolf, RHIT, CPC, CEMC**, is one of those leaders whose dedication is noticed by her chapter and who instills pride within her team. Here is what the Minneapolis chapter has to say about Wolf's leadership and its effects on the chapter:

"... JoAnne, you were a great leader and that is why we have this honor."

—2013 Vice President **Kelly Jo Moore, CPC, CEMC**

"I am so incredibly proud to be a part of this chapter as well as a board member this year ... Thanks JoAnne for all you do!"

—2013 Treasurer **Suzanne Taylor**

"JoAnne, you are a great leader and do so much for the chapter! You've always made everyone feel welcome and helped the chapter to where it is today ... I am also honored to have served with you and to be in this chapter. I love being part of a great team and having great coding friends. Minneapolis members are the best! Thank you ALL."

—2012 Vice President **Pam Tienter, CPC, CPC-P, CCS-P, CPC-I**

"I am so glad that I took a risk and put myself out there this year to become an officer. I am so enjoying working with all of you [officers]! JoAnne, you were, and still are, such a great leader; and have earned such respect from everyone in the chapter ... I'm excited to say that I'm from the Minneapolis chapter!"

—2013 Secretary **Amy J. Conroy, CPC**

"I am also honored to be part of the awesome team and truly thankful for the strong leadership JoAnne has provided us all over the years. There is a reason why she has received 'Chapter Member of the Year,' year after year!"

—2012 Secretary **Cindy A. Elliott, MA, CPC**

This is why I never switched to closer local chapters when they first started up; the extra driving is so worth it to stay with this group of friends." Moore is now 2013 vice president of the Minneapolis chapter.

Members Can't Stay Away

The Minneapolis chapter prides itself on the ability to make all members feel valued. New members are acknowledged and given a heartfelt welcome, as well. According to Wolf, chapter meetings start off with congratulating members who recently obtained coding credentials, followed by asking for a show of hands of any new members or first-time attendees. Officers make it a point to reach out to these new members so they feel welcome. "Most importantly, it's the atmosphere of our chapter meetings that gets new members to keep coming back," Wolf said.

2013 Treasurer **Suzanne Taylor** is an example of how Minneapolis' welcoming support of new members is what keeps her attending meetings. She said, "I am not even a coder yet and I have had so much support from this chapter over the last year and a half. I look forward to another wonderful year."

Future Brings More Charity, Leadership, and Education

Minneapolis says they have big plans in store for 2013. Along with continuing their charitable activities, they are focusing on strengthening leadership by:

- Educating chapter members on chapter officer roles and their duties
- Asking members to approach an officer if interested in the position and shadowing them
- Encouraging members to take on leadership roles within the chapter

Minneapolis said they will continue to provide quality coding education and as many specialty CEUs as possible at chapter meetings to accommodate the diverse members with specialty credentials.

St. Louis West, Missouri
Region 5

Award Ceremony at AAPC's 2013 National Conference in Orlando: Angela Jordan and Marti Johnson present St. Louis West Chapter officers Barbara Fontaine and Debbie Flieger with the 2012 Chapter of the Year award.

Mixing things up and trying something new is what made the St. Louis West Chapter stand out in 2012. According to then-President **Debbie Flieger, CPC, CPC-H, CPMA, CPPM, CPC-I**, "We really took the chapter in a new direction in 2012. We went out on a few limbs, shook things up a bit, and tried our best to provide the best education and most fun for our members."

In the spirit of being adventurous, here's what St. Louis West ended up accomplishing, according to AAPC's Local Chapter Officer/Member Liaison Emilie Nelson:

- Held a seminar with 347 attendees.
- Held additional meetings and exams to accommodate members.
- Held review classes to help members prepare for their exams.
- Held a job fair to help members who were seeking employment opportunities.
- Held multiple fundraisers and raised over $800 for the AAPCCA Hardship Scholarship Fund.
- Held a food drive for a local food pantry and collected school supplies for a local women's shelter.
- Worked with schools in their area to invite students to come to their meetings and become AAPC members.
- Encouraged members to become active on the AAPC Forums by presenting a monthly "Question the President."
- Raised over $7,000 to provide scholarships for their members to attend national, regional, and local conference.
- Held a Trivia Night and invited their member's friends and families to come to the meetings.

Achieving so many great things takes dedicated, amazing people. Congratulations to St. Louis West Chapter members and last year's officers who went above and beyond chapter requirement to achieve this award. The 2012 officers were:

- President: **Debbie Flieger, CPC, CPC-H, CPMA, CPPM, CPC-I**
- Vice President: **Elizabeth "Betsy" Miller, CPC, COBGC**
- Member Development Officer: **Rhonda J. Bottoms, CPC**
- Secretary: **Barbara Fontaine, CPC**
- Treasurer: **Ileana Stewart, BS, CPC**

Honored and Thrilled to Be Winners

St. Louis West, with over 900 members and 50-70 in attendance at meetings each month, has been setting a high bar of excellence for many years. In fact, upholding a higher standard is how they run the chapter. Fontaine, who is now 2013 member development officer, said, "We have been striving for many years to be Chapter of the Year, not because we have to do it, but because it's the way we want to run our chapter. All the guidelines are things that every chapter should try to do, and do well. For St. Louis West, it's just being consistent and putting our members first."

Left to right: Ileana Stewart, Rhonda Bottoms, Debbie Flieger, Barbara Fontaine, Elizabeth (Betsy) Miller

The chapter is beaming with pride for winning the 2012 Chapter of the Year award. Stewart, who is now 2013 president, said that she "felt excited and thrilled to be recognized for all of our hard work."

Miller says she displays her award so all can see. She said, "I am so proud of us! Ever since I was given my 2012 Chapter of the Year award certificate, I put it out on my desk everyday."

Supported by Leaders

Fontaine says she thinks the St. Louis West chapter is unique because it has a long line of strong leaders who continue to set higher standards. She said, "I think we have a long tradition of good leadership. Many of our past presidents are still attending chapter meetings and are invited to be part of our chapter board as we plan and carry out events." Their knowledge and experience strengthens newer officers and helps the chapter grow. Fontaine continued, "Having access to their history and experience makes all the difference. We are always trying new things, and they are there working with us and rooting us on."

What also makes the St. Louis West Chapter unique is that they "have many members, both new and long-term, who are willing to step up to leadership positions," according to Stewart. And Miller said Flieger is a perfect example of someone who is willing to step up and do great things. She said, "The reason I believe we won is due to our AMAZING president, Debbie Flieger. She is a true go-getter, I know of nothing that she wants to accomplish that she has not been able to."

Belonging through Volunteering

Volunteering has created a foundation for belonging in St. Louis West Chapter. Bottoms said, "Our officers and members are very friendly and eager to volunteer to keep our chapter going. Officers listen to the members and make decisions based on suggestions and responses from the membership."

Volunteering isn't something just seasoned members and officers do in St. Louis West Chapter: New members are also invited to help, too. Flieger said that new members "are greeted and welcomed at the meeting, announced during the business meeting, and encouraged to volunteer and network. Bottoms added, "We offer them opportunities to volunteer at future chapter events, so they can meet more members and really feel like part of our chapter."

The best part is that because they have such a dedicated group of volunteers, they can do more fun activities and charity events, such as the Job Fair; AAPCCA Hardship Scholarship Fund and local, regional, and conference funds; food drives; seminars, and Trivia Night.

Packing the Coders in at the Education Round-up

2102 brought a colossal "Education Round-up" for coders. Flieger said, "We hosted our biggest EVER local conference in November, 'Education Round up;' we had 347 attendees 24 vendors." The round-up brought in high profile AAPC speakers such as:

- AAPC Vice President, ICD-10 Training and Education **Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC**
- 2011-2013 AAPC National Advisory Board President **Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P**
- 2013-2014 AAPC Chapter Association **Chair Brenda Edwards, CPC, CPMA, CPC-I, CEMC**

Besides being chock full of top-notch education, the round-up was a hoot. Flieger said, "We made it fun with our rodeo theme, stick horse races, coding shoot out, and cash machine." Giddy up St. Louis West!

More Fun and Excitement on the Horizon

In 2013, St. Louis West said they will keep thinking outside of the box for new ways to continue chapter growth and being fabulous. Their future goal is "to encourage attendance and networking, to grow educational opportunities, and to bring variety to the membership," said Flieger. Realizing these goals should be a breeze since "fun education" and "affordable CEUs" have always been the big focus for St. Louis West, which has proved variety is the spice of life.

Are Two Chapters in the Cards for Next Year?

If you're wondering whether there is a chance two chapters will be honored with this award next year, Johnson's answer is, "No, we don't plan on having a tie next year; it's just Minneapolis and St. Louis West really stood out this year." This is a one-time deal, and AAPC was fortunate in 2012 to have had two exemplary chapters honored with this prestigious award.

Michelle A. Dick is executive editor at AAPC.

By Andrea Umbreit, MPA

Gold Nuggets to Manage Medical Records Workflow

Use these practical tips to help you get your practice running at maximum efficiency.

Congratulations! You have a shiny new electronic health record (EHR) system. You carefully selected your EHR, trained your staff, and evaluated workflow and technology. Now you must keep up with ongoing medical records management. Although you probably cringe at the thought of doing it, it's required to keep your practice running like a well-oiled machine. Here are some practical tips to help.

Don't Be Penny Wise, Pound Foolish

Don't try to make money or cut costs where it doesn't make sense. For example, practices often bill patients who request their medical records (release of information), even though staff can't handle the billing and tracking of these payments or state guidelines don't allow reasonable compensation for this effort. Practices that pre-bill for release of information generally collect on only a small percentage of those requests. And the effort of the pre-billing actually represents 90 percent of the time and resources needed to fulfill the request. Avoid this pitfall by analyzing whether it makes sense for you to charge for this service in your state. If you're averaging less than $8 per request, it's not worth your time to bill.

Avoid HIPAA "Overkill"

The average practice cannot possibly keep up on thousands of pages of ever-changing Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. Many practices lack the HIPAA expertise needed, while others go totally overboard.

The average practice ... cannot possibly keep up on thousands of pages of ever-changing regulations.

Analyze who is doing what and when and you'll learn a lot about misused human resources.

If you feel you are over-documented, duplicating efforts, or spending too much time covering your electronic protected health information (ePHI), you probably are. Consult with your compliance specialist, attorneys, or EHR resources to be sure you are covering the requirements only. Unnecessary medical record documentation takes time away from your clinic and patients.

Plug Staffing Leaks

Ask yourself:

- Are you paying clinical staff to file, route, and appropriate documents that enter the EHR because you don't have the administrative staff to do so?
- Is the practice administrator covering the phones and scheduling when the front desk staff are out?
- Do you have "down times" that aren't filled with backup projects?
- Is your medical records staff running up against the 30-day HIPAA deadline a bit too often for comfort?

Analyze who is doing what, and when, and you'll learn a lot about misused human resources. Redistribute tasks to match the skills and expertise of your trusted staff. Allow everyone to work at the top of his or her specialty and certification, and rearrange or outsource workflow from there.

Define Your Record Set

Ask yourself:

- Do you know when you're allowed to send out medical records to attorneys?
- Should you allow your payers on site in your EHR during an insurance audit?
- Should records from other providers be included in your documentation?

The not-so-simple solution is to document these in your internal policies to be clear about what is and is not included in your designated record set, as well as the resources used to review your legal requests. Review your payer contracts annually and update them as needed.

Calculate Your True Costs

There are some super-organized folks out there who have a neat and tidy line item for medical records. As for the rest of us—dealing with more work, shrinking budgets, and information overload—we have a hunch as to what we spend keeping this workflow afloat.

If you have no idea what your medical records management really costs you, but you can come up with a number you believe is 85-90 percent within a reasonable range, start with that number and look for savings and efficiencies. Gather sample data, make educated assumptions, and start measuring and tracking from there.

Sign Business Associate Agreements, Pronto!

The latest HIPAA ruling has made several significant changes to strengthen policies. If you don't have a business associate (BA) agreement in place with your vendors, do so immediately. Appropriate agreements allow you to transfer some HIPAA liability to your partners. If you don't have an agreement written with your vendors, ask them to supply one. Keep yourself covered and limit your risk.

For more information on the implications of the new ruling, read the article "New Final Rule Changes HIPAA Provisions and HITECH Applicability" on page 56 of this issue of *AAPC Cutting Edge;* also check out this link from Forbes Law Group: www.datafiletechnologies.com/wp-content/uploads/2013/01/HIPAA-Final-Rule-Newsletter.pdf.

Get Started

First, change your way of thinking and evaluate the opportunities technology and outsourcing have to offer. A few changes could save you or your department a few hours per week, or a few hundred dollars per payroll. More importantly, put stronger measures in place to prevent risks in your ePHI, while also employing your human resources to their maximum.

Andrea Umbreit, MPA, is director of business development for DataFile Technologies, a remote medical records management partner for healthcare groups of all sizes. You can contact Andrea at solutions@datafiletechnologies.com.

By Jamie Verkamp and Rachel Granatino

Your Practice Needs Both Leaders and Managers

"Leadership and management must go hand in hand. They are not the same thing."

—Alan Murray, deputy managing editor for the Wall Street Journal.

Illustration by iStockphoto©dsco77

There are many different types of leaders. There's the seasoned employee who motivates others to be as productive as he is, or the receptionist who's quiet, but always gets her work done and treats everyone with respect, inspiring others to do the same. Both exhibit leadership qualities and both types of workers are essential components of a successful business, but only one would make a great manager.

Without Both, You Tip the Scales

Leadership is an important quality in a manager. If a manager is not able to inspire and motivate staff to excel, employees lack direction, and efficiency and morale decline. Conflict may also arise when an individual with the wrong type of leadership skills is placed in a management position.

Many workers are solely focused on function, and define their job as reaching performance goals and meeting organizational standards. You may think of these people as leaders because they're great at "getting a job done," but when employees focused solely on their own output are promoted to management the rest of the staff is set up for failure.

Some individuals are natural leaders, whom everyone looks up to due to their charisma, enthusiasm, and overall positive attitude toward work and life. These personalities tend to be more socially motivated than task oriented, however. When these leaders take on a managerial role, productivity may decline due to a lack of clear direction.

Often, billing supervisors are promoted because they have been with the company for many years and are excellent coders. They'll need more than that to succeed in management, however. These employees are often

Frontline managers and supervisors can make or break an organization.

expected to continue performing their previous roles, in addition to monitoring, motivating, coaching, and guiding those who now work under them. This is a lot to take on, and success requires these people to be personable and have the right type of leadership skills.

The challenge facing many healthcare organizations lies in how to internally promote employees into management without setting them up for failure.

Ideal Mix: A Hard Worker Who Motivates Others

The magic formula is finding managers who are able to lead and inspire others, as well as have the drive to complete tasks and exceed requirements. When hiring or promoting from within, it's important to look for qualities from both sides of the spectrum, rather than impressive marks in one area or the other.

If you're tasked with filling a management position, keep in mind that skills can be taught, but behaviors are hard to change. If hiring from within, ask yourself:

- Does this person exhibit a natural tendency to inspire others?
- Does he or she participate in meetings, engage in conversations, and share ideas for making improvements to the organization and its processes?
- Do co-workers like and respect the individual?

Ask your external candidates to share specific examples of how their co-workers responded to their leadership; and ask how they contributed to their department or organization. Certain pre-hire assessments can also help to determine candidates' natural aptitude to lead and inspire others.

Finding the right managers from either internal promotions or an outside search can be daunting, but this is not a position you just want to "fill." Frontline managers and supervisors can make or break an organization. Managers are responsible for directly affecting the attitude and culture of your organization. You need them to be able to effectively relate information from physicians, administrators, and other leaders to the staff.

Become an Effective Leader

If you're considering management as the next step in your career, there are several ways you can prepare to be the best candidate for the role and achieve success.

1. **Tell your supervisor or department head that you wish to be considered for management.** Discuss what is expected of managers, any necessary training, and other specifics of the job. The more you know about the career path you are choosing, the better you can prepare yourself.

   Don't shy away from talking with current management team members about their roles, and asking for their recommendations to best prepare you for entering the management track. Start these conversations early to allow time to complete courses and hone other skills necessary to be a better leader.

2. **Read, read, read.** The more books, articles, and training courses you can complete, the more you will know and the better you will look in the application process for a management position.

Many books have been written on how to understand, motivate, and lead people. Your organization may offer leadership courses, or you can look into local colleges and universities to see if they offer professional management or leadership courses. The more you can educate yourself on how to motivate and lead people, the better manager you will be.

Take a good look at YOUR motivators for entering a managerial role. For example:

- Do you enjoy inspiring people?
- Are you willing to do the work no one else wants to do so you can lead by example?
- Are you willing to coach people, listen, problem-solve, and be a cheerleader of your peers?

If you can answer "yes" to all of those questions, you are well on the right path to becoming an exemplary leader and manager. Good luck in your journey!

Jamie Verkamp is a seasoned healthcare consultant, working and owning businesses in this sector for more than 10 years. As managing partner at (e)Merge, a medical growth consulting firm, she works with medical professionals in hospital and clinical settings to improve patient experience and her clients' customer service efforts, referral volumes, and bottom lines. As a speaker and trainer, Verkamp shares her knowledge with audiences at more than 40 events per year, speaking on new marketing initiatives, patient experience, and health care social media.

Rachel Granatino, director of marketing and social media at (e)Merge, uses her passion for advertising and social media in the healthcare industry to design creative campaigns, promote strategic messages, and assist in developing comprehensive plans to drive improvement within the market. She can be found in hospitals, clinics, and association meetings across the country, training on patient experience and social media marketing and assisting clients in developing strategies and implementing best practices to achieve their goals.

By Marcia Brauchler, MPH, CPC, CPC-H, CPC-I, CPHQ

Contract Negotiation

Four Strategies to Help You Master Contract Negotiations

Part 5: Take expert advice to make payer negotiations less of an endurance test and improve the final outcome.

Negotiating is a difficult skill to master. To help with your next payer negotiation, I've compiled lessons learned the hard way and condensed them into simple strategies. This advice is for contract negotiators who have no legal expertise. Consult a lawyer for final input on all contract language before executing an agreement.

Strategy No. 1: Get Organized

Preparation can be intimidating, but it's worth the effort: When you are better organized and prepared than your counter-negotiator, you have the upper hand.

Be organized. Label everything. Put the contract in order (using a three-ring binder) as if you're a lawyer preparing for trial. On cross-examination, you'll need quick access to the facts. You'll be surprised how voluminous the binder becomes after a few meetings and drafts.

Organization is a good foundation for whatever comes next. If you're disorganized, the shear volume of paper will discourage you. Here are some tips for organizing your binder:

- Color-code your binder. If one contract negotiation requires multiple binders, keeping one contract in the same colored binder helps to identify it more easily.
- Use a manila folder for working documents (but quickly move them behind a tab in your binder). Use chronological order behind labeled tabs, with the most current information on the top.
- Don't throw anything away. Years from when you

Takeaways:

- Be better prepared and organized than your counterpart.
- Assess your position and your payers'.
- Look carefully and understand a number of sections that could prove pitfalls if mishandled.

finish the negotiations, you may need to refer to something that came up in the negotiations. You'll want to have documented evidence to support your statements.

- Write everything down, with names and dates attributed to verbal statements. This will ensure promises made in negotiations make it into the final draft of the contract. It's also useful for your side if later the payer tries to commit you to something they claim you said in negotiations.

Strategy No. 2: Assess Your Position and the Payer's

Size up the competition through research. Determine all of the reasons why this contract is (or isn't) necessary to you. You don't want to spend the same amount of time and attention on a contract for services you don't intend to use as you would for services you intend to use 80 percent of each day.

With regard to the payer's operations, try to identify (or ask up front):

- Does the payer have fully-insured business, or only administer self-insured business?
- Is the payer really just a rental network of providers?
- Who are the payer's major group accounts?
- Does the payer market heavily to individuals and seniors?
- Does the payer have a Medicare Advantage contract?
- Does the payer have a Medicaid health maintenance organization (HMO) contract?
- Which products does the payer offer, such as HMO, preferred provider organization (PPO), federal employee program (FEP), etc.?
- How many insured members does the payer have in your state?
- What does the existing payer network look like in regard to hospitals that are in-network, other physicians, and ancillary networks (such as lab, vision, imaging, behavioral health, etc.)?
- What local coverage determinations, preauthorization procedures, or formulary restrictions of the payer affect your practice?
- What quality indicators does the payer track for your specialty?

Strategy No. 3: Make a Checklist of Key Terms

Create a checklist of relevant points you want to touch on before you read the contract. For example, what do you expect the contract to cover and what do you want it to say? Document this by category (such as payment, term, penalties, etc.).

A sample checklist of questions and points to review in the contract, and information you need to know about the health plan during negotiations, might include:

Type of Agreement:

- Will this be a group or an individual agreement?
- What product lines are to be contracted (e.g., HMO, PPO, EPO, Medicaid, Medicare Advantage, Workers' Comp, etc.)?

Amendment:

- Does the contract allow for simple notification if documents are modified, or is a written agreement required for each modification?

Term, Termination, and Renewal:

- Is there an initial term during which you can't terminate your participation?
- Is there "without cause" termination? Are the requirements for notice the same for both parties?
- Does a term take effect after 90 days (or other period), or upon the renewal date?
- Does the contract require providers to perform services after the contract terminates?
- What is the term of the contract? Is there an automatic renewal clause?

Claim Filing and Payment:

- What is the timely filing limit for you to submit claims after the patient's date of service?
- Does the contract reference your state's prompt payment law?
- Is there a time limit for the plan to recoup or offset?

Organization is a good foundation for whatever comes next. If you're disorganized, the shear volume of paper will discourage you.

photo by iStockphoto/Turn-Hours

Compensation:

- How does the plan compensate physicians (fee-for-service, per case, capitation, etc.)?
- Are there annual dues, credentialing fees, or other upfront physician costs?
- If physicians are paid using a multiple of resource-based relative value scale, on which year are payments based? When does the year, conversion factor, or relative value units change?
- How are non-Medicare-valued services (such as preventive exams, some labs, injections, and immunizations) paid?

Strategy No. 4: Skim the Contract

I'm convinced the recitals and definitions are put at the beginning of the agreement to wear out unsuspecting readers. The reimbursement is always an attachment at the very back of the agreement. Skim the agreement the first time through, locating the key data that you outlined in your checklist. Focus on what matters most, and don't get lost in the verbiage.

If the reimbursement is totally out of line, don't read the agreement. I suspect sometimes the other party hides the reimbursement, hoping that after you've invested hours in reading the entire agreement you'll agree to the reimbursement only so the whole process wasn't a waste of time. Don't let this happen to you!

Get an electronic copy of the contract so you can make redlined changes as you go. In the worst-case scenario, you can retype the agreement. It's better to give your own proposed language than allow the other side to paraphrase your thoughts.

The standard layout of a contract is fairly consistent. If you are familiar with the base form agreement used by most health plans, you'll be able to get beyond the layout and concentrate on the content. The most significant sections of a typical health plan contract for professional services is shown on the next page.

In our next installment, we'll provide you with more contract negotiating tips.

Marcia Brauchler, MPH, CPC, CPC-H, CPC-I, CPHQ, is the founder and president of Physicians' Ally, Inc., a healthcare consulting firm and concierge billing company for specialty physician practices. Brauchler works with physicians on managed care contracts, reimbursement, and practice administration. Her experience includes hospital, health plan, and independent practice association administration. Brauchler is a published researcher and a frequent public speaker.

Here's an overview of the significant sections of a typical health plan contract for professional services:

PREAMBLE

The preamble identifies the parties of the contract, including their formal names, state of origin or residence, and other status. Often, this section includes the execution date, or the date the agreement is to become effective.

RECITALS

The recitals provide an explanation of the parties' roles and the purpose for the agreement. The recitals are NOT terms and conditions. Changes to this section should be made only to restate facts, not to convey agreement terms.

DEFINITION

The definition section is a glossary of terms used throughout the agreement. In the event a dispute arises between the parties about a particular term, the meaning of the term as it is defined in this section will take precedent over generally accepted usage. Do not overlook the importance of this section. It may contain material terms and the agreement's conditions. You should negotiate the definitions until you are comfortable with their meaning and scope.

SERVICES/OBLIGATIONS OF PROFESSIONAL

This section states what the physician must do as a party to the contract. It's amusing to note the number of physician obligations versus the health plan's obligations (I've seen 55 professional obligations to three health plan obligations). Beware of unusual obligations that add undue burden or costs to the physician for just one payer.

SERVICES/OBLIGATIONS OF HEALTH PLAN

The health plan generally will be responsible for promotion and advertising of the plan to new enrollees, overseeing quality and utilization management, and credentialing of providers.

COMPENSATION

The agreement should set forth how the physician will be compensated. It generally covers:

(1) Fee schedule amounts;

(2) Billing and payment requirements;

(3) Adjustments to compensation, such as payment after the agreement terminates; and

(4) Coordination of benefits (COB).

COB refers to the determination of which two or more health benefit plans shall apply, either as primary or secondary coverage, for services to a patient. Such coordination is intended to preclude the provider from receiving an aggregate of more than 100 percent of covered charges.

TERMINATION

The term of the agreement is the length of time the agreement will remain in effect. The date the agreement is signed by the parties is not always the "effective date." Some payers determine the effective date after receiving the partially executed agreement. Some agreements provide for automatic renewal for additional years without requiring either party to do anything. In these agreements, the term of the agreement is generally defined as the "initial term." Extended terms are later years.

COMPLIANCE WITH LAWS AND LICENSURE

The agreement may specify that both parties will comply with applicable laws, rules, and regulations in carrying out their respective obligations under the agreement.

UTILIZATION MANAGEMENT, QUALITY IMPROVEMENT

This provision usually describes the managed-care organization's programs. It generally refers to procedures fully described in the provider manual or health plan policies and procedures. You should require advanced notice of any changes in these programs and procedures before you agree to comply with them.

COMPLAINT RESOLUTION/ARBITRATION

Usually, this section provides an alternative to legal proceedings. Typical language requires arbitration and tries not to give an advantage to one party over the other.

ACCESS TO RECORDS

This section of an agreement usually discusses the physician's obligation to maintain medical records in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state law. It usually allows the payer access to records for audits during normal business hours, with advanced notice. It might cover reasonable reimbursement for copying records.

INDEMNIFICATION

As a general rule, we recommend having the physician's or practice's malpractice carrier provide suggested indemnification language consistent with the coverage of your policy. For example, if the base language requires the practice to indemnify the payer but your insurance carrier won't cover that, you could then suggest each party remain liable only for its own actions. Suggested language might be:

Indemnification/Hold Harmless. Professional shall be liable for any and all claims, costs and expenses arising from or out of any alleged negligent act or omission of Professional, its agents or employees, in the performance of its obligations under this Agreement. HEALTH PLAN shall be liable for any and all claims, costs, and expenses arising from or out of any alleged negligent act or omission of the HEALTH PLAN, its agents or employees, in the performance of its obligations under the Agreement.

CONFIDENTIALITY

Payers generally include language stating the physician may not disclose the terms of the agreement to any other party. Plans also like to list information that might be considered specifically proprietary.

AMENDMENT

Payers typically offer language that allows the payer to unilaterally amend the agreement. A non-response obligates the practice to the terms of the amendment. Instead, we recommend language enabling either party to amend the agreement only through mutual written consent. Suggested language to propose would be, "Amendment. This Agreement may be amended only by prior mutual written agreement of the parties."

MISCELLANEOUS/GENERAL PROVISIONS

This section usually includes terms for the:

- "Entire Agreement," which means this agreement supersedes any other verbal or written agreement, such as items discussed in negotiations;
- "Assignment," which is generally written to allow the payer to assign the agreement if the payer is sold to another health plan, but prohibits the physician from doing the same;
- "Governing law," which should be the state in which you practice; and
- "Notices," which is where you add to whom and where any official notice should be directed for you and for the payer, etc.

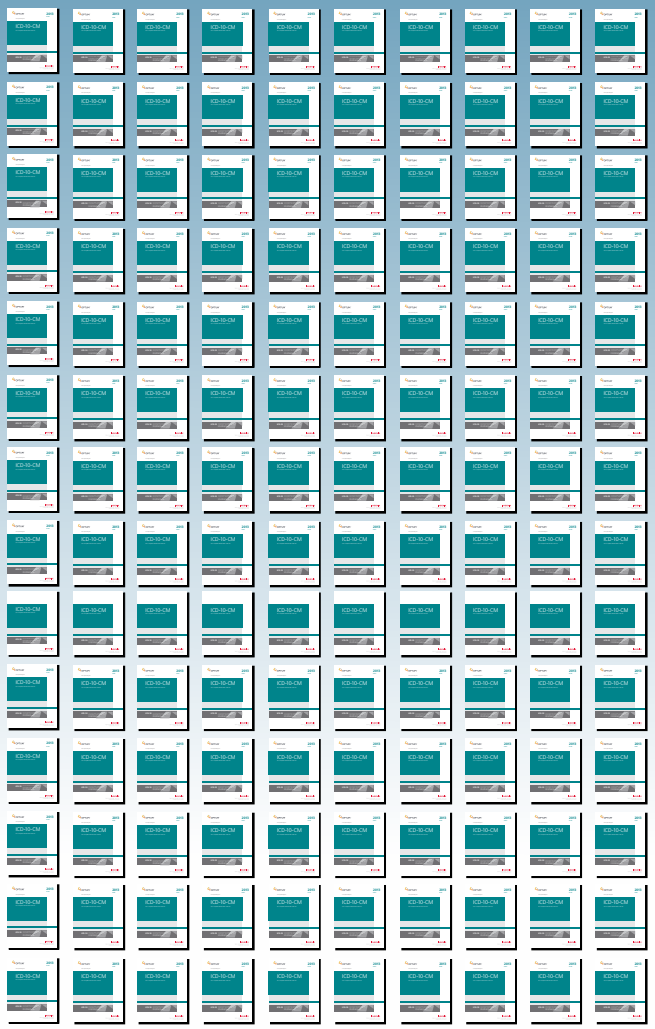
ICD-10 BRINGS BIG CHANGES.
BIGGER OPPORTUNITIES.

ICD-10-CM/PCS
(takes effect Oct.1, 2014)

668%
INCREASE

ICD-9-CM

about **18,000** unique codes



about **140,000** unique codes

= 1,000 codes

140,000 CODES. ACCESSIBLE IN SECONDS.

Simplify ICD-10 with *EncoderPro.com* from Optum™.

ICD-10 will have 668% more codes than ICD-9 — but that doesn't mean the transition has to be overwhelming. As an affordable, simplified alternative to coding books, *EncoderPro.com* — the industry leader for web-based coding, billing, and compliance solutions — provides one-click access to ICD-10 codes, data, and mapping tools as well as CPT® and HCPCS code sets.

60,000 Users

Rely on *EncoderPro.com* —
Maybe it's time to learn why.

Call: 1.800.464.3649, option 1

Visit: optumcoding.com/transition

AAPC members get special pricing.
Be sure to mention promo code AAPCe13.

OPTUM™

By Barbara Aubry, RN, CPC, CHCQM, FAIHCQ

Reducing Readmissions Is a Team Effort

OIG is targeting high rates for these services, so work together to be sure yours are necessary.

As a regulatory analyst for 3M Health Information System, I spend a portion of each day reviewing regulatory changes and updates, Office of Inspector General (OIG) actions, the Centers for Medicare & Medicaid Services (CMS) releases, and a myriad of healthcare industry news feeds. My goal is to track what the industry is up to from a regulatory perspective and determine how those changes are likely to affect physicians and hospitals.

The Story Behind Same-day Readmissions

The OIG "mines" claims data to identify patterns and trends. They look for specific criteria—usually anything that gives the appearance of overutilization, overcharging, upcoding, or poor quality of care.

Years ago, facilities could charge a diagnosis-related group (DRG) for each admission. Based on trends in claims data, the OIG wondered if hospitals might be encouraging readmissions to increase revenue. Based on this, in 2004 CMS implemented an edit to reject subsequent claims for beneficiaries who were readmitted to the same hospital on the same day. Per the *Medicare Claims Processing Manual* (Pub. 100-04, ch. 3, § 40.2.5), "If a same-day readmission occurs for symptoms related to or for evaluation or management of the prior stay's medical condition, the hospital is entitled to only one DRG payment and should combine the original and subsequent stays into a single claim."

OIG Takes Aim at Same-day Admissions

Same-day hospital readmissions are part of the OIG's 2013 Work Plan, and they are serious: *The New York Times* reported that in the fall of 2012, CMS levied financial penalties against 2,127 hospitals believed to have high readmission rates ("Hospitals Face Pressure to Avert Readmissions"). Of that total, 307 will be penalized 1 percent of revenue for every regular Medicare admission for the next five years. The penalties result in multimillion dollar losses for some facilities.

It comes as no surprise that the federal government will continue its focus to reduce healthcare costs. Medicare spent $556 billion in 2012 with a projected growth rate of 4 percent per year. It's expected the government will recoup $300 million in readmission penalties this year alone.

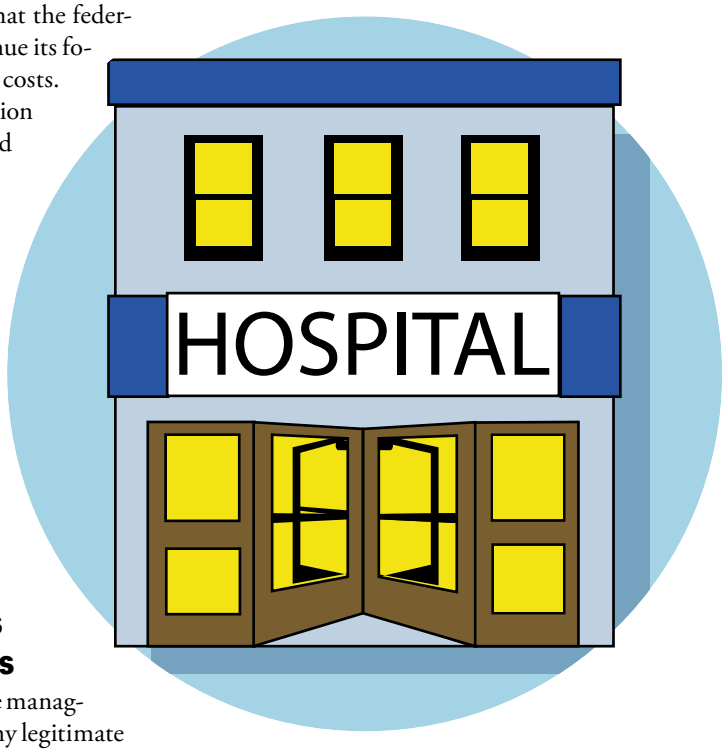
Readmission rates are too high—I don't think anyone will argue against that. But there are legitimate cases during which readmission can occur.

Clinical Reasons for Readmissions

As a nurse and former case manager, I am familiar with many legitimate

Takeaways:

- The OIG "mines" claims data, looking for anything that gives the appearance of overutilization, overcharging, upcoding, or poor quality of care.
- Same-day hospital readmissions are part of the OIG's 2013 Work Plan.
- Coders are in a unique position to recognize readmission trends, and can help curtail a noncompliance issue.



Recognizing trends is not only the purview of the OIG.

(and unfortunate) reasons for readmissions. These include:

- Poorly managed chronic illnesses
- Multiple diagnoses causing complications
- Medication, treatment, follow-up noncompliance
- Lack of understanding of the discharge plan
- Poor discharge teaching
- Language barriers
- Inability of the discharge planner to get needed services in the home on the day of discharge
- Limited or nonexistent family or community support
- Concomitant mental illness, substance abuse, or other disability
- Age, frailty, homelessness
- End-of-life needs not met because patient is not in hospice

I could go on, but you get the drift. People have many complicated physical, emotional, and psycho-social needs that must be met. When those needs are not met, they return to the hospital, where they are able to get the care required.

In addition to clinical reasons for readmissions, there are other reasons, as well. Sometimes, a bed is urgently needed by a sicker patient and early discharges must be made; or patients may use up their allotted days of healthcare coverage based on utilization review and are prematurely discharged.

Look for Trends

By now you may be wondering how coders can impact readmission rates. It's actually quite simple: You, the coder, know best the diagnoses most often seen. Not only do you recognize the diagnoses, but you begin to learn the names of the frequent flyer patients because they are often in house. You are a valuable resource and your knowledge should be shared to help reduce readmissions.

You will see patterns: For instance, Dr. X's chronic heart failure patients bounce back on a regular basis. The usual scenario is: emergency department (ED) visit, observation, short stay admission, discharge, followed by ED admission for the same complaint and diagnosis. As you identify such trends, consider how to share them in a meaningful way. Recognizing trends is not only the purview of the OIG.

Speak Your Mind

When you recognize trends, use your knowledge and share it. It may be difficult to find the time because you are expected to code X number of records per day, upon which your productivity is measured. If you have a regular team meeting, tell your supervisor there is something you'd like to discuss. If you don't have regular meetings, ask to meet with your manager one-to-one.

Go to the OIG website (https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/WP01-Mcare_A+B.pdf) and print out the specific text on same-day readmissions. Discuss with your manager the patterns you have noticed. Be prepared with a list of the diagnoses and DRGs you see in the patterns.

Offer to share what you've noticed with utilization review, case management, documentation improvement, or any other area in health information management (HIM) compliance that focuses on medically unnecessary or questionable readmissions. Sharing any trends that reflect quality of care can be important to helping improve readmission rates in your facility.

Take the Next Steps

In some facilities, coders work together with documentation improvement nurses. But coders also have value for case management and utilization review because they notice trends of which the nurses may not be aware.

When you recognize trends, use your knowledge and share it.

If you can, make copies of the cases supporting the trends to share with the nurses. Remove protected health information, unless there is a reason they need to see it. Even though you work on the "back end" and code same-day readmissions that have already taken place, share that knowledge with those who can affect the current admission status. This is especially important in facilities that repeatedly assign the same care manager to a certain floor or service. This person knows the status of her floor or area, but is likely unaware there is a readmission problem originating in the ED.

Make It a Team Effort

Improvement does not happen in a vacuum. Hospitals, like many businesses, tend to form silos where useful information is not shared. Suggest to your HIM manager to consider assigning a coder to work with the compliance officer, in addition to case management and utilization review.

Each individual discipline brings more useful information to the table for discussion. When the information is shared, strategies emerge that benefit everyone. Perhaps your compliance office would like to know every time there is a case of XYZ discharged within ABC time frame with DRG 000 because she is aware the OIG is requesting that data for a planned audit. Who better to provide that information than a coder?

Barbara Aubry, RN, CPC, CHCQM, FAIHQ, is a senior regulatory analyst at 3M Health Information Systems. She is responsible for analyzing CMS and other payer rules and regulations and communicating how the changes impact 3M customers. Aubry works with development, planning and marketing. She also creates and maintains data and is heavily involved in ICD-10 translation of NCD policies for CMS. Previously, Aubry was utilization review manager at Holy Name Hospital, director of peer review and audit for a privately owned company, and manager of the department of utilization management for an East Coast HMO.

By Stacy Harper, JD, MHSA, CPC

CMS Addresses Part B Inpatient Billing Controversy

Find out how a new ruling and a proposed rule will affect your claims processing.

Takeaways

- CMS has released rules substantially affecting how hospitals are reimbursed for Part B services when a Medicare contractor denies payment for such services under Part A.
- The ruling permits hospitals to submit claims and receive reimbursement for Part B services when a Part A claim is denied.
- The language of the proposed rule, if finalized, will have significant implications on a hospital's ability to be compensated for reasonable and necessary medical services.

photo by iStockphoto©Shevchenko91

Due to a recent controversy in claims payment, the Centers for Medicare & Medicaid Services (CMS) issued Ruling 1455-R on March 13 and a proposed rule on March 18. The rules substantially affect how hospitals are reimbursed for Part B services when a Medicare contractor denies payment for such services under Part A based on findings that the inpatient admission was not reasonable and necessary.

In recent years, Medicare audit contractors, including recovery audit contractors (RACs), have scrutinized inpatient hospital claims and frequently contested whether the admitting physician's decision for inpatient services were reasonable and necessary. Contractors alleged more often than not that certain services are more appropriately provided in the outpatient setting, and would subsequently demand repayment under Medicare Part A.

Although analysis finds services could (and should) have been billed as Part B outpatient services, CMS historically has taken the position that hospitals are not entitled

Medicare audit contractors, including recovery audit contractors (RACs), have scrutinized inpatient hospital claims and contested whether the admitting physician's decision of inpatient services are reasonable and necessary.

to payment because proper Part B claims for these services were not filed in a timely manner. This position has been repeatedly reversed by the Medicare Appeals Counsel of the Departmental Appeals Board (DAB), and is being challenged in a lawsuit brought by the American Hospital Association.

Know How CMS Ruling 1455-R Affects Billing

The March 13 ruling reverses CMS' historic position and implements the holdings of the DAB regarding these claims. The ruling permits hospitals to submit claims and receive reimbursement for Part B services when a Part A claim is denied by a contractor due to a determination that it is not reasonable and necessary. Payment for Part B services will be made as long as those services are reasonable and necessary and would have been paid if the patient had originally been treated as an outpatient (except for services that specifically require outpatient status).

For example:

Dr. Brown admitted Susie Smith as an inpatient to the hospital for performance of a cardiac catheterization. Ms. Smith was in the hospital for 36 hours of monitoring following the procedure. The hospital submitted the inpatient bill for services to Part A and received payment. Some time later, a Medicare auditor reviewed the service and determined the procedure could have been performed as an outpatient with monitoring provided as outpatient observation.

Under CMS Ruling 1455-R, the hospital could now submit a Part B claim for outpatient services, including the cardiac catheterization. The claim, however, cannot include the services for outpatient observation because these services specifically require an outpatient order for submission to Medicare, which the hospital does not have.

Medicare contractors are instructed to waive timely filing requirements and accept these Part B claims even when they are not submitted within *one* year of the date of service. This ruling applies to Part A hospital claims denied by a Medicare contractor prior to the effective date of the ruling, but for which the time to appeal has not expired, or for which an appeal is pending. The ruling will no longer apply on the final rule's effective date for these services.

To Be More Specific

Similar to the interim ruling, the proposed rule permits hospitals to receive reimbursement under Part B for services as if the patient had originally been treated as an outpatient, except for services that specifically require outpatient status. The proposed rule permits this payment when a Medicare contractor determines services were not reasonable and necessary, or when the hospital itself, in a post-discharge self-audit, makes the same finding.

The proposed rule does not apply to all Part A claims that are subsequently denied by Medicare contractors as not reasonable and necessary. Medicare contractors currently may review claims up to five years from the date of service. The proposed rule will only permit payment of the corrected Part B claim by a hospital if it is submitted within *one* year of the date of service. Part B claims presented more than one year from the date of service will continue to be denied for untimely filing, without the possibility of an appeal.

The proposed rule also does not permit adjustment by the reviewer who makes the Part A denial determination. The hospital must separately submit the claim for Part B services. This is primarily relevant because a Part B claim cannot be submitted when an appeal to the Part A determination is filed by the provider or the patient. As such, the hospital must either waive its appeal rights related to the Part A reasonable and necessary determination to timely file the Part B claim; or appeal the Part A determination and waive the right to reimbursement for any Part B services.

The Bottom Line

The language of the proposed rule, if finalized, will have significant implications on a hospital's ability to recover reasonable and necessary services when there is disagreement regarding the setting where the services should be provided. The comment period for the proposed rule ended May 17. A final ruling is expected later this year.

The information contained in this document is to alert you to legal developments and should not be considered legal advice. If you would like more information, please contact Lathrop & Gage LLP or your attorney.

Stacy Harper, JD, MHSA, CPC, is of counsel with Lathrop & Gage LLP in Overland Park, Kan., and serves on the National Advisory Board for AAPC. She focuses her practice on regulatory compliance and healthcare reimbursement. Harper has experience as a physician practice office manager and compliance officer. She has firsthand knowledge of the legal and practical reimbursement structures for government and private payers. Harper assists providers with the successful resolution of reimbursement disputes related to claims denials, audits, and appeals. She also offers an in-depth understanding of the federal and state regulatory environment affecting healthcare.

By Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC

Understand Pain Management from an Auditor's Perspective

Payers say unbundling of pain management codes is a real problem, and they're on the lookout for offenders.

Takeaways:

- Pain management services are more common than ever.
- Unbundling alarms payers, especially with bilateral procedures.
- It's probable the OIG will target pain management services in 2014.

The number of providers offering pain management has grown considerably in recent years, with anesthesiologists, in particular, branching out to provide these services. As providers are billing more and more pain management services, payers are paying closer attention, and are finding cause for concern. Specifically, payers say they are finding a disturbing number of improper payments due to unbundling.

Unbundling Promises Pain

"Unbundling" occurs when services are reported with individual codes when there is a single code that encompasses all the services performed. As a coder, you must know what's included with services to prevent this common coding error.

For example, coding guidelines clearly state that CPT® 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* is done under guidance. Yet, many providers additionally code CPT® 77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)*.

That's unbundling. If a payer finds they paid separately for services that should have been included in another payment, they'll want their money back (at a minimum).

As a second example, consider CPT® 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopic or CT); cervical or thoracic, single level*: Here again, reporting the injection and guidance separately is unbundling. For procedures performed with ultrasound guidance, the proper code is 0228T *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level*. Check your documentation to determine your provider's approach regarding guidance. If documentation does not support reporting the Category III code, inform your physicians of this requirement.

Bilateral Procedures a Cause for Concern

What if a facet joint injection is performed on both sides of the cervical or thoracic joint? CPT® guidelines allow you to report 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* with modifier 50 *Bilateral procedure*, thereby gaining the provider a 50 percent reimbursement hike.

In the same situation just described, some providers will have the patient come in Monday for the right side injection, and then return Tuesday for the left side injection. With zero global days attached to 64490, there is nothing to say providers can't treat their patients this way. But from a coding and auditing perspective, it's a red flag if this occurs on every occasion. Some auditors find this to be an abusive way to increase revenue because the second procedure is reimbursed at 100 percent, rather than reduced to 50 percent payment when reported on the same day with modifier 50.

photo by iStockphoto/©dougfir537

If a payer finds they paid separately for services that should have been included in another payment, they'll want their money back ...

Note, however, that physicians providing these pain management services often administer the first injection as a unilateral treatment. If the patient tolerates the procedure, bilateral injections are provided for subsequent services. This practice, when documented, would support billing for the injections on separate days.

Differentiate Epidurogram from Fluoroscopic Guidance

Another troubling issue is providers who bill for an epidurogram (e.g., 72275 *Epidurography, radiological supervision and interpretation*) when fluoroscopic guidance is more appropriate.

For example, imaging is performed on the veins lining the spinal canal with an injection of contrast material under fluoroscopy, allowing the provider to examine the space surrounding the nerves to diagnose stenosis, herniations, and swelling. Often in such cases, documentation shows that fluoroscopic guidance, rather than epidurgraphy, was performed.

Report 72275 only when the images are documented and a separate report is issued. Because the service includes both technical and professional components, be sure to append modifier 26 *Professional component* when claiming only the physician work (e.g., the physician does not own the equipment and/or pay the staff). In cases where you are coding the facility portion (but not the physician's work), append TC *Technical component*.

It's likely the Office of Inspector General (OIG) 2014 Work Plan will investigate potential over-treatment in pain management, especially as it relates to unbundling and the "creative" coding done by some physicians.

Good advice: Audit your pain management claims now to ensure you're on the right side of the law when a payer comes knocking.

Example

The patient was taken to the operating room, placed in the prone position, and monitors were placed. The back was prepped with Betadine using sterile technique. An oblique fluoroscopic view was obtained. After alignment of the end plates, the superior articular process of each respective joint aligned with the adjacent pedicle. A 2 cc of Lidocaine 1% was infiltrated subcutaneously at the 6 o'clock position of the respected pedicle using a 27-gauge 1.5" needle. Following this a 22-gauge 3.5" spinal needle was introduced through the skin wheal and aimed for the 6 o'clock position of the pedicle. Bony contact was made and the needle was gently walked off and advanced into the transforaminal space under lateral fluoroscopic view. Confirmation needle placement was done using several AP, oblique, and lateral views. A 0.5 cc of Isovue® contrast medium was injected at each respective level in the AP view. Contrast medium was seen traversing the transforaminal epidural space medially, and along the respective nerve root laterally, and there was no intravascular uptake. This again was confirmed using multiple fluoroscopic views. Gentle aspiration proved negative for heme or CSF prior to injection of steroid solution. Next, a 3 cc solution was prepared using 1 cc of Lidocaine 0.5% (plain, preservative free) and 1 cc of Depo-Medrol® (40 mg/mL), and was injected without complication at each of the respective levels.

In this case, the provider wanted to report 72275—even though he states fluoroscopic views multiple times. Reporting a formal contrast study such as an epidurography requires a separate report, as well.

Take note: The documentation says "a 3 cc solution," but in the chart note there are only 2 cc's accounted for, leaving the coder to query the provider about the additional medication said to be used.

Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC, is coding and billing manager for Travis C. Holcombe, MD. She has 20 years of coding and billing experience, is an AAPC workshop presenter and AAPC ICD-10 trainer, and served on the AAPC National Advisory Board (NAB) from 2007-2009. Ward was the 2012 president of the West Valley Glendale chapter, and has held offices with the Phoenix chapter. She is also a member of the 2012-2013 AAPC-CA board of directors, region 8-West.

By Michael D. Miscoe, JD, CPC, CASCC, CUC, CPCO, CCPC, CHCC

Coding Compass

New Final Rule Changes HIPAA Provisions and HITECH Applicability

photo by iStockphoto © Warchi

Review how clarifications can impact your protected health information (PHI) use and disclosure.

In 2010, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, which mandated changes to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. Then, on Jan. 17, 2013, the U.S. Department of Health & Human Services (HHS) Office of Civil Rights (OCR) published the final rule, "Modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules," significantly revising the act. Let's take a look at how these revisions will affect your practice.

Business Associate PHI Liability Is Expanded

The HITECH Act made the Breach Notification Rule, significant portions of the HIPAA Security Rule, and specific HIPAA Privacy Rule provisions directly apply to business associates. The final rule clarifies who a business associate is and how the HITECH Act's provisions pertaining to business associates are applied.

Business Associate Agreements Extend to Subcontractors

OCR clarifies that only data transmission services requiring routine access to PHI are considered business associates. OCR also clarifies who is considered a subcontractor. It still requires a business associate agreement with all subcontractors who have access or use PHI as part of their contracted function with the covered entity. It extends this requirement to entities the subcontractor retains to accomplish any function that requires the use and disclosure of PHI.

For example: Assume a provider (Doctor A) subcontracted its billing function to a third-party billing service (ABC Billing). ABC Billing would be a business associate, and as such, it has direct liability for any violation of HIPAA. Doctor A is required to execute a business associate agreement with ABC Billing. If ABC Billing subcontracted work to another person (Outside Coder)—such as an inde-

The definition of business associate includes any person or entity that creates, receives, maintains, or transmits PHI on behalf of a covered entity.

pendent contract coder (including those in another country)—then Outside Coder is liable under HIPAA. Not only is Outside Coder subject to HIPAA liability, but Doctor A must execute a business associate agreement with Outside Coder. For this to occur, Doctor A must require, as part of the agreement with ABC Billing, that it disclose the identity of Outside Coder so Doctor A is able to execute the appropriate business associate agreement with that subcontractor.

Who Needs a Business Associate Agreement?

The definition of "business associate" includes any person or entity that creates, receives, maintains, or transmits PHI on behalf of a covered entity. The word "maintains" was inserted to address entities that store or maintain PHI on behalf of a covered entity, even though they never access or view the PHI. These entities include companies providing physical storage of paper records or facilities serving providers with online backup and storage of electronic PHI. All of these are now considered business associates under HIPAA and a business associate agreement is required.

The final rule also clarifies that when a covered entity discloses PHI to a healthcare provider for purposes of treatment, the healthcare provider is not considered a business associate of the disclosing covered entity.

Business Associate Liability Under the Revised HIPAA Rules

Consistent with the preliminary rule, business associates and their subcontractors are now directly liable for violations of the HIPAA Security Rule and for uses and disclosures in violation of the HIPAA Privacy Rule. As a result of these changes, business associates (which includes their subcontractors who are also considered business associates under the final rule) must address the following in the business associate agreement:

- Business associates must keep records and submit compliance reports to HHS when HHS requires such disclosure to investigate the business associate's compliance with HIPAA and to cooperate with complaint investigations and compliance reviews (45 CFR § 160.310(a), (b)).
- Business associates must disclose PHI, as needed by a covered entity, to respond to an individual's request for an electronic copy of his or her PHI (45 CFR § 164.502(a)(4)).
- Business associates are required to notify the covered entity of a breach of unsecured PHI (45 CFR § 164.410(a)).
- Business associates must make reasonable efforts to limit use and disclosure of PHI consistent with the minimum necessary disclosure rule in response to requests for PHI (45 CFR § 164.501(b)(1)).
- Business associates—just like providers—must provide an accounting of disclosures of PHI (76 *Federal Register* 31426, May 31, 2011) and must execute agreements with subcontractors that comply with the Privacy and Security Rules (45 CFR §§ 314(a)(2)(iii); 164.504(e)(5)).

PHI for Marketing Use Has Further Restrictions

Consistent with the prior rule, use or disclosure of PHI for "marketing" purposes remains permissible, with the patient's written authorization. A revision in the final rule, however, provides additional restrictions on PHI use and disclosure in cases where the covered entity received remuneration connected to its use or disclosure.

Under the new rule, marketing is defined as covered entities that **use PHI to identify individuals** for the purpose of receiving communication about an item or service and that **receive a form of monetary compensation from a third party** to communicate with the targeted individuals.

The original rule defined marketing simply as communicating about a product or service to encourage individuals to purchase it. The prior rule, however, loosely defined exceptions to marketing that permitted a practice to describe to its patients the products, services, or alternative treatments on behalf of others without being characterized as "marketing." The final rule amends the definition of marketing and it now encompasses treatment or healthcare operations communications about health-related products or services where a practice (or business associate) receives remuneration from the entity whose product or service is being described (45 CFR § 164.501).

For example: If a physician office shares PHI with drug companies for payment so the drug company can pitch its products to the physician office's patients, that's engaging in marketing.

Marketing Exceptions

The final rule also states that financial remuneration can be either direct or indirect payment from, or on behalf of, the third party whose product or service is described in the marketing material.

Covered entities that maintain records in designated electronic record sets must provide an electronic copy of the patient's medical record for the patient.

The official comments to the regulation, however, clarifies that financial remuneration does not include in-kind (non-cash) benefits provided to a covered entity in exchange for making the communication (78 *Federal Register* 5566 at 5593, Jan. 25, 2013).

Existing exceptions for face-to-face communication (78 *Federal Register* 5566 at 5596, Jan. 25, 2013) remain intact in the final rule, as do communication about *currently* prescribed medications (e.g., communication about prescription refills, generic substitutes, or instructions for taking the drug). These activities are not considered marketing as long as any remuneration received for making the communication is limited to the covered entity's cost in making or sending the communication (45 CFR § 164.501).

Sale of PHI Needs Patient Authorization

The sale of PHI to third parties remains impermissible without the patient's written authorization (45 CFR §§ 164.502(a)(5)(ii)(A), 164.508(a)(4)). Any written authorization must detail what will be disclosed and to whom, and must expressly indicate that the permitted disclosure of PHI will result in remuneration to the covered entity. Written authorization is required for both financial and non-financial remuneration. As a result—and unlike the marketing rule—remuneration associated with the "sale" of PHI involves *anything* of value. Beyond this clarification, the final rule does provide a number of exceptions, which are found at 45 CFR 164.502(a)(5)(ii).

Provision of Electronic Copies of PHI

The final rule adopts the following rules pertaining to electronic protected health information (ePHI) and patient use:

Providers Must Supply Copies in Compatible, Risk-free Formats

Covered entities that maintain records in designated electronic record sets must provide an electronic copy of the patient's medical record for the patient. The electronic form and format requested by the patient must be readily producible by the covered entity. If the form or format requested by the patient is not readily producible, the covered entity is obligated to produce an electronic copy of any ePHI in at least one readable electronic format.

To be compliant with this rule, you can provide the electronic data on a flash drive or compact disk, send a secure email with the attached file, or provide secure web portal access to the patient's medical record.

Note: If using the latter two methods, perform relevant risk analysis and update your HIPAA Security Policies to address potential PHI disclosure risk and methods of minimizing such risk.

Rules for Providing Entire Patient Records

Unless the patient requests a subset of his or her record, the practice must provide all PHI held by the practice (covered entity). Practices are not required to purchase specific software to accommodate requests for certain document formats, although the practice must be able to produce some form of readable electronic copy. If the electronic file contains links to images or other documents, those images or documents must also be provided.

If the entire record is part paper and part electronic, the practice is not required to convert paper records to electronic form (for example, scanning to portable document format (PDF) or other image format). The practice is, however, obligated to disclose the paper records, as well as ePHI. As a result, if it's more cost effective to scan the paper records and provide a single electronic record containing all PHI, the practice may do so when the entire record is requested by the patient.

Patients Should Not Supply Storage Media

A covered entity is not required to use media provided by the individual for storage of the ePHI because media provided by the patient may contain virus files or other files, creating security concerns for the practice. Because this is a real concern, the HIPAA Security Policy should address this circumstance and expressly prohibit use of patient supplied media.

Know the Rules for Sending Unsecure Email

If the practice does not have secure email and the patient requests his or her PHI sent via email, the practice may send ePHI via unsecure email only *after* advising the individual of the risks of a third-party viewing. The notice of risk must be sent separately before sending the unsecure PHI email. Obtain the patient's expressed acknowledgement of the risk.

To avoid this circumstance altogether, look into secure email services that "plug in" to most email programs. Besides providing a secure method of submitting ePHI to patients, it also provides secure and encrypted communication between employees. It's not uncommon for physicians to email PHI obtained at another site back to their office and vice versa. Because secure email is encrypted, no breach occurs even if the email is accidentally sent to the wrong person or is intercepted through the Internet.

photo by iStockphoto©2012

Coders!

Are your doctors' E&M coding skills flatlining?

Ron Haberman, MD, CEMC

By design, The *Pocket CPT©System* is completely different from what the other consultants try to deliver but usually fail at. As both a physician *and* a certified E&M coder, I know exactly how your doctors think and how to reach them.

Call me to discuss how the Pocket CPT©System can help your docs get their coding where it needs to be.

Benefits

The Pocket CPT©System can help your practice:

- Stop leaving money on the table from underbilling
- Reduce the risk of triggering audits from overbilling

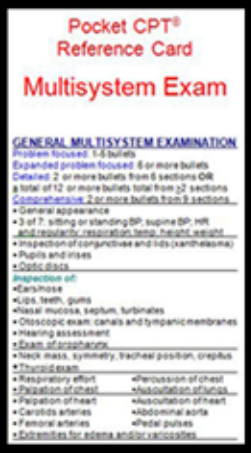
How it Works

- The key to the System is the copyrighted Pocket CPT© Reference Card, which allows doctors to see a patient and immediately assign the correct code.

The System

The Pocket CPT©System incorporates:

- Extensive physician E&M coding education
- The Pocket CPT© Reference Card
- Chart audits (fee included as part of full program)
- On-site and virtual educational programs
- Monthly coding tips videos targeting physicians



Pocket CPT®
Reference Card

Multisystem Exam

GENERAL MULTISYSTEM EXAMINATION
Problem focused: 1-5 bullets
Expanded problem focused: 6 or more bullets
Detailed: 2 or more bullets from 6 sections OR a total of 12 or more bullets total from ≥2 sections
Comprehensive: 2 or more bullets from 9 sections
- General appearance
- 3 of 7: sitting or standing BP, supine BP, HR and regularity, respiration, temp, height, weight
- Inspection of conjunctivae and lids (xanthelasma)
- Pupils and irises
- Optic discs

Inspection of:
- Ears/nose
- Lips, teeth, gums
- Nasal mucosa, septum, turbinates
- Otoscopic exam: canals and tympanic membranes
- Hearing assessment
- Exam of oropharynx
- Neck mass, symmetry, tracheal position, crepitus
- Thyroid exam
- Respiratory effort
- Palpation of chest
- Percussion of chest
- Auscultation of lungs
- Palpation of heart
- Carotids arteries
- Auscultation of heart
- Abdominal aorta
- Femoral arteries
- Pedal pulses
- Extremities for edema and/or varicosities

The Pocket CPT©Reference Card is laminated and folds down into 2½" by 5", easily fitting into any shirt or jacket pocket.

There are 11 different reference cards, one for each Medicare-defined examination area.

See our introductory video at

www.PocketCPT.com

304-690-2012

Info@PocketCPT.com

... providers may now include reasonable labor costs for the technical time spent in creating or copying electronic or paper records.

Photo by iStockphoto © Baton72

Safeguard Third-party PHI Transactions

When requested by the patient, a practice must transmit the electronic copy of the patient's PHI directly to the third person designated by that individual. From a security policy perspective, although the practice may rely on the individual's request as authorization to send PHI to a third party, the practice must implement appropriate policies and procedures to verify the identity of the requesting individual and implement appropriate and reasonable safeguards to protect the information disclosed.

You Can Charge Reasonably for Copy Costs

If a patient requests paper or electronic copies of PHI, you can charge for the reasonable costs associated with producing the requested copies. The final rule clarifies that providers may now include reasonable labor costs for the technical time spent in creating or copying electronic or paper records.

Reasonable cost-based fees may also include the cost of supplies used such as electronic media or paper and postage for mailing. According to the final rule, however, fees may not include new technology costs, costs for maintaining PHI in electronic form, or a retrieval fee. Keep in mind when establishing fees that there is a state law preemption provision in HIPAA that disallows covered entities from charging fees in excess of the state statutory limits.

Respond Quicker to PHI Requests

The final rule decreases the maximum time a covered entity has to respond to a request. A covered entity has 30 days to provide requested PHI and is permitted a one-time, 30-day extension. The practice must notify the requesting individual of the need for a 30-day extension, the reason for delay, and the expected date the records will be produced. There is no longer an exception allowing an additional 30 days to respond when records are stored offsite. These time guidelines apply regardless of whether records are stored in electronic or paper form.

Clarify Concerns by Reviewing the Final Rule

Study how these new clarifications impact the way in which PHI is used and disclosed. Be certain to revise present HIPAA privacy and security policies to meet the requirements of the final rule. Failure to do so could involve higher-tier sanctions following a breach on the basis the covered entity's policies and procedures were noncompliant.

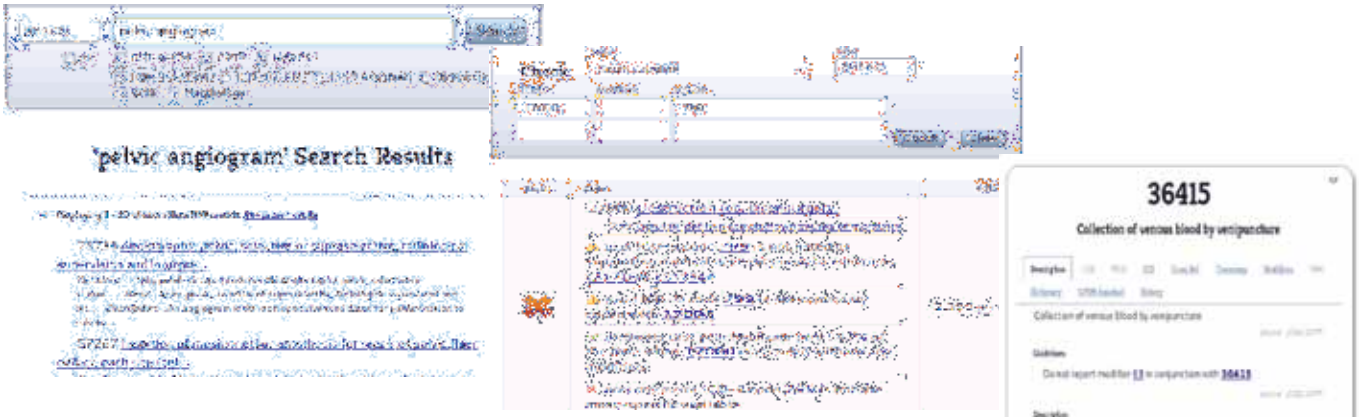
Michael D. Miscoe JD, CPC, CASCC, CUC, CPCO, CCPC, CHCC, has a Bachelor of Science degree from the U.S. Military Academy, a juris doctorate degree from Concord Law School, is president of Practice Masters, Inc., and founding partner of Miscoe Health Law, LLC. He has served on AAPC's NAB, is a current member of the Legal Advisory Board, and is chair of the Legal Ethics Committee. Miscoe is admitted to the Bar in California and to practice law before the U.S. Supreme Court and the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. He has 20 years of experience in health care coding and over 16 years as a compliance expert, forensic coding expert, and consultant. Miscoe has provided expert analysis and testimony in civil and criminal cases, and represents healthcare providers in post-payment audits and HIPAA OCR matters. He is a national speaker and a published author.

The Coding "Revolution" Has Arrived!

Coders and Auditors spoke and NAMAS listened! Introducing "Revolution", the first and last coding tool you will ever need. Coding software programs for years have provided only pieces of what is needed to provide complete and accurate coding for medical practices...UNTIL NOW!

The Coding Revolution has arrived and is going to revolutionize the way coders and auditors perform their jobs, and at a price the industry has never seen before. There is so much this program does we can't print it all on one page…

$79.00 per month gets you unlimited access to a world of information and efficiency never experienced before.



Revolution is the most comprehensive and complete code look-up and search engine in the market today! Revolution will significantly reduce errors and Let our system be your workhorse behind the scenes!

- Search across any or all of our libraries at once ***including a full ICD-10 library***!
- Auto-complete assistance in the search box
- Proprietary ranking algorithm
- Allows you to search any of our libraries at once
- Auto completes as you type
- Gives suggestions for misspellings
- Displays results using our proprietary ranking
- NCCI (CCI) Edits
- Fee Schedules
- National and Local Coverage Determinations (NCD)/(LCD)
- CPT® and HCPCS Modifiers
- CPT® Guidelines
- ICD-9 Specificity
- Common CPT® and HCPCS Modifier Usage

NATIONAL ALLIANCE OF MEDICAL NAMAS ACCREDITATION SERVICES

www.codingrevolution.com

The National Alliance of Medical Accreditation Services ("NAMAS") is dedicated to advancing the professional careers of health care staff for physician-based services. Revolution is powered by PitchstoneHealth.

By Melody S. Irvine, CPC, CPMA, CEMC, CFPC, CPC-I, CCS-P, CMRS

Perseverance Pays Off in Job Market

AAPC certifications changed my life and supported my career advancement.

Life is tough and so is the job market. Making the best out of the cards you are dealt and looking for educational opportunities when they arise can make the difference between success and failure. Here is the story of my career path and credentials I carry to show you that when one door closes, another one opens.

1980: Getting a Foot in the Door

I just had my first child, but I couldn't afford to be a stay-at-home mom; I had to find a job. I did not have direction or a career path, but I was fortunate to find employment as a hospital operator. I worked the 3-11 p.m. shift on weekends and holidays. The hours were not the most convenient, but it paid well, had benefits, and I did not have to pay for full-time daycare.

1981-2000: Gaining Practical Experience

Over the next nine years, I had another child and held positions at the same hospital in admission, data entry, and the billing department. I built a reputation as a hard worker and was offered a position with a local physician group of six family physicians. Little did I know at the time that I was at the start of an amazing career.

Over the next 15 years, I worked in nearly every position in the physician's office, from scheduling, front desk, medical records, and referrals, to billing and coding. I learned all I could from each position, and I never said, "No, that's not my job."

In 1993, I was raising two young boys by myself. I had reached the level of billing/coding supervisor within the first five years with this physician group, but advancing within the organization looked bleak, and I wasn't sure how we would survive on my current wages. My self-esteem and self worth were at an all-time low. I didn't know where I was going in my life and career; all I knew was that I wanted to provide for my sons the secure and bright future they so much deserved.

2002: Seeking Certification to Further Career

My physician group joined with several other multi-specialty groups to become a large physician practice. During the reorganization, an administrator approached me about the possibility of advancement. They wanted me to be their director of coding; however, I had one missing criteria to meet: I had to be a certified coder. Fortunately for me, I was hired for the position and given one year to obtain my certification.

I acquired my Certified Professional Coder (CPC®) credential in 2003. The certification gave me confidence, boosted my self-esteem, and gave me a feeling of value. I was asked to help develop the compliance plan for the practice and was promoted to director of the practice's urgent care facility.

After reaching these goals, the physician group informed me I had to learn evaluation and management (E/M) auditing—I hated E/M codes! They were confusing and very intimidating, but I didn't have a choice. I was lucky to work for a fantastic physician who understood E/M coding extremely well, and he volunteered to guide me. We took all of the classes together and learned more about auditing.

As the years moved on, so did my career. I left my position with the physician group and was hired to develop and implement the medical billing and coding curriculum for a

I learned all I could from each position, and I never said, "No, that's not my job."

technical school. Later, I decided to open my own school and consulting firm. With hard work and good fortune, I have been successful.

30 Years and Seven Credentials Later

I now have seven certifications, five of which are from AAPC. I worked very hard to obtain them—none were easy to earn, and I'm not fond of tests. People ask me, "Why so many certifications?" It's not because I want to have all of these acronyms behind my name, it's because each certification shows expertise and advanced knowledge in a specific area. Each credential made a difference in employment and my career path. Employers have told me they are hiring me specifically because of my certifications.

My career has been 30 years in the making. It took many hours of hard work and sacrifices. My career was at a dead end until I decided to make some changes. AAPC certifications made a difference in my life and career. Don't let anyone tell you, "You can't do it." I'm proof that you can.

Melody S. Irvine, CPC, CPMA, CEMC, CFPC, CPC-I, CCS-P, CMRS, is co-author of the CPMA curriculum and soon to be releasing her second auditing book. She served on the AAPC National Advisory Board from 2009–2013 as Member Relations Officer.

newly credentialed members

Alina Dawson, **CPC**
Allison Anderson, **CPC**
Alyshia Baker, **CPC**
Amanda Giannino, **CPC**
Andrea Kern, **CPC**
Angela Bridget Martin, CPC, **CPC-H**
Anitha Ilangovan, **CPC**
Annamarie Kuebbeler-Martin, **CPC**, CPMA
Anne Scott, **CPC**
April Marie Fraley, **CPC**
Arjun Tirupathi, CPC, **CPC-P**
Ashley Elizabeth Williams, **CPC**
Ashlie Witkop, **CPC**
Ashok Kumar Nishad, **CPC**
Ashwini M, **CPC**
Barbara Rodriguez, **CPC**
Barbara Smith, **CPC**
Benta A Kalul, **CPC**
Betsy Flowers, **CPC**
Bridgett Lenette Calip, **CPC**
Brittany Merritt, **CPC**
Cara Anne Jimenez-Belen, **CPC**
Carol A Kaiser, **CPC**
Caryn Wagner, **CPC**
Chanda Colwell, **CPC**
Charlene Nicks, **CPC**
Chastity Sorenson, **CPC**
Christie Blenden, **CPC**
Christopher N Omolo, **CPC**
Christy Michelle Harrison, **CPC**
Crystal Wright, **CPC**
Cynthia Cone, **CPC-H**
Darlene Marie Brown, **CPC**
Dawn Bales, **CPC**
Dawn McFarland, **CPC**
Deana Jefferson, **CPC**
Deb Fillmore, **CPC-H**
Devee Balasubramanian, **CPC**
Dhara Gupta, **CPC-H**
Diane Bryand, **CPC**
Dianne Marquis, **CPC**
Dianne Nicholson, **CPC**
Elaine M. Mckeown, **CPC**
Elizabeth Sanders, **CPC**
Ellen Cavalier, **CPC**, CPC-H
Erin Fruechting, **CPC**
Felicia M Goode, CPC, **CPC-H**
Gajendhiran Palaniappan, **CPC**
Gerilyn Murphy, **CPC**
Hanna Parks, **CPC**
Harmony Salebe, **CPC**
Ignatia J Agus, CPC, **CPC-H**, CCC
Jamie A Sloan, **CPC**
Jean Ann Costa, **CPC**
Jeff Long, **CPC-H**
Jennifer Cerulli, **CPC**
Jennifer Falk, **CPC**
Jennifer Flinn, **CPC**
Jennifer Latva, **CPC**
Jennifer Nellums, **CPC-H**, CIRCC
Jessica Gabel, **CPC**
Jessica Harnack, **CPC**
Jessica Herrera, **CPC**
Jill Marie Nakashima, **CPC**
Joanne Marie Ingrasselino, CPC, **CPC-H**, CEMC, CUC
Jodie Nichols, **CPC**
Josue Marcus Garcia, **CPC**
Judy Louise Brown, **CPC**
Kapil Arora, **CPC**
Karan Bhardwaj, **CPC-H**
Karen J Sakarcan, **CPC**
Karren Y Smith, **CPC**
Kelli Dennis, **CPC**
Kelly Maczuga, **CPC**
Kelly Turner, **CPC**
Kendra Nilson, **CPC**
Keri Hughes, **CPC**
Krishna Kant, **CPC-H**
Kristen Mary Mershon, **CPC**
Kristi Yvonne Couch, **CPC**
Kyle Williams, **CPC**
Laureen Jandroep, CPC, **CPC-H**, CPPM, CPC-I
Lisa Carter, **CPC**
Lisa Heavlin, **CPC**
Lisa V Scott, **CPC**
Magdalena Jandura, CPC, **CPC-H**
Mahipal Singh, **CPC**
Maria Myers-Sephes, **CPC**
Marsha Meyer, **CPC**
Marsha T Flagg, CPC, **CPC-H**
Mary Lindsey, **CPC**
Mary Pendleton, **CPC**
Mary T Walsh, CPC, **CPC-H**
Mehmood Ali, **CPC**
Melissa Hudzik, **CPC**
Melissa Sheard, **CPC**
Michelle Ann Garnett, **CPC**
Michelle M Heimbach, **CPC**
Moira Anjanette Jerry-Green, **CPC**
Nelly Romero, **CPC**
Nicole Statley, **CPC**
Nicole Toomsen, **CPC-H**
Nithyapriya Aruchamy, CPC, **CPC-H**
Oriana Stoja, **CPC**
Pam Girard, **CPC**
Parul Sinha, **CPC**
Patricia A Chene, **CPC-P**
Patricia N Belew, **CPC**
Praveen Kumar Nallabalapu, **CPC**
Ranjitha K M, **CPC**
Rebecca Elizabeth Chase, **CPC**
Renee Vincent, **CPC**
Rita Arnick, **CPC-H**
Rita Everett, **CPC**
Robin L Wootten, **CPC**
Robynn Westerwick, **CPC**
Rohit Shrikant Mhatre, **CPC**
Rosemary Margaret Koch, **CPC**
Sabrina Bruce, **CPC**
Sachin Arora, **CPC-H**
Sajida Begum B, **CPC-H**
Sanjeev Sharma, **CPC**
Sarah Brieger, **CPC**
Saranya Snl Varada, **CPC**
Shahnawaz Khan, **CPC-H**
Sharmistha De, CPC, **CPC-H**
Sharon Snow, **CPC-H**
Sheethal Viswanath, **CPC**
Shubrena L Harrison, **CPC-P**
Sridharan K, **CPC-H**
Stacie N Essenfeld, **CPC**
Stephanie Johnson, **CPC**
Stevie Jolene Wolfe, **CPC**
Summer Ann Gallegos, **CPC**
Susan Camacho, **CPC**
Susan DeLisle, **CPC**
Susan Lewandowski, **CPC-P**
Suvarna Cheruku, **CPC**
Tammie R Olson, **CPC**
Tasha Yoder, **CPC-H**
Terri Hunter, **CPC**
Tina Andranovich, **CPC-H**
Tina Buhrmaster, **CPC**
Tobie Copp, **CPC**
Trivia Holmes, **CPC**
Upasana Ayyappan, **CPC-H**
Victor Ochieng Onyaye, **CPC**
Yadira Avila, **CPC**
Yuliya Romanoff, **CPC**
Yvette Steagall, **CPC**

Apprentices

A Kiranmai, **CPC-A**
Aamod Kumar, **CPC-H-A**
Abby Fritts, **CPC-A**
Abhinay Tripathi, **CPC-A**
Adep Venkatesh, **CPC-A**
Aftab Alam, **CPC-A**
Alayna Brantner, **CPC-A**
Alice Marie Adams, **CPC-A**
Alma Delia Zarate, **CPC-A**
Amanda Readman, **CPC-A**
Amber Carter, **CPC-A**
Amber Irons, **CPC-A**
Amber Malone Wright, **CPC-A**
Amber Mitchell, **CPC-A**
Amber R Perkins, **CPC-A**
Amy L Stoner, **CPC-A**
Amy Scott, **CPC-A**
Anand Kumar Rajpurohit, **CPC-A**
Andra Thomas, **CPC-A**
Andrea Chapin, **CPC-A**
Andrea Giesecke, **CPC-A**
Andrea L Wilson, **CPC-A**
Andrew Martin Baumgardner, **CPC-A**
Andrew Shine, **CPC-A**
Angela Proietti, **CPC-A**
Angela Santana, **CPC-A**
Angelita Rodriguez, **CPC-A**
Angie Lee, **CPC-A**
Angie Spitzer, **CPC-A**
Anis Fathima Shahul Hameed, **CPC-A**
Anita Akel-Soileau, **CPC-A**
Ann Cantrell, **CPC-A**
Anna Fye, **CPC-H-A**
Anna Reynolds, **CPC-A**
Anthony Pangilinan, **CPC-A**
Anup Ramesh, **CPC-A**
April Sturgis, **CPC-A**
Ashwini Vasant Patil, **CPC-A**
Audra Anderson, **CPC-A**
Babu Sivasankaran, **CPC-A**
Bajaru Shravan Kumar, **CPC-A**
Becky Kundert, **CPC-A**
Benjamin Javier, **CPC-A**
Beth Butsko, **CPC-A**
Bikshapathi Theegala, **CPC-A**
Bonnie Lees, **CPC-A**
Bonnie S Stangl, **CPC-A**
Bonnie S Varnell, **CPC-A**
Brian Dyson, **CPC-A**
Brittany Leigh Locklear, **CPC-A**
Candace Verna Edwards, **CPC-A**
Carmel Sileo, **CPC-A**
Carmen Butler, **CPC-A**
Carol Seto, **CPC-A**
Carolyn Vickers, **CPC-A**
Carrie Kaye Gaiter, **CPC-A**
Charmaine Green, **CPC-A**
Charulatha Rajagopal, **CPC-A**
Cherryl Mangilin, **CPC-A**
Cheryl Romero Soriano, **CPC-A**
Chinmoy Baruah, **CPC-A**
Chris Orr, **CPC-A**
Christina M Schultz-Conroy, **CPC-A**
Christine Bergeron, **CPC-A**
Christine Hagdar, **CPC-A**
Christopher Mathews, **CPC-A**
Cindy Goehring, **CPC-A**
Cindy Marie Cercone, CPC-A, **CPC-H-A**
Cini Menon, **CPC-H-A**
Clarissa Sue Gibson, **CPC-A**
Claudette Fraser, **CPC-A**
Colette Nagao, **CPC-A**
Connie E Deville, **CPC-H-A**
Craig Peterson, **CPC-A**
Cristina Castaneda, **CPC-A**
Cristine Humiston, **CPC-A**
Crystal Ann Elliott, **CPC-A**
Crystal Dickerson, **CPC-A**
Cynthia O Martinez, **CPC-A**
Cynthia O'Grady, **CPC-A**
Cynthia Smith, **CPC-A**
Dacia Bellow, **CPC-H-A**
Daljit Clark, **CPC-A**
Darron Abeita, **CPC-A**
David G Archuleta, **CPC-A**
Dawn Overman Jackson, **CPC-A**
Debbie Cranford, **CPC-A**
Debbie McDonald, **CPC-A**
Debora Long, **CPC-A**
Deborah Hanrahan, **CPC-A**
Deborah Hein, **CPC-A**
Deborah Lynn Eisenbrey, **CPC-A**
Debra E Byrnes, **CPC-A**
Debra Lannom, **CPC-A**
Deepa Sivaraj Nadar, **CPC-A**
Deepak Kumar, **CPC-A**
Demonica Ann Broadway, **CPC-A**
DeWayne Thompson, **CPC-A**
Diana Ashcraft, **CPC-A**
Diane Solon, **CPC-A**
Dinkar Prasad Pandey, **CPC-A**
Divya Ahuja, **CPC-A**
Dolores Bristol Villorente, **CPC-A**
Donald Lenard, **CPC-A**
Dorys Abad, **CPC-A**
Durga Devi P, **CPC-A**
Edward Townley, **CPC-A**
Eknath Reddy Pochal, **CPC-A**
Ekta Tripathi, **CPC-H-A**
Elangovan Jayaraman, **CPC-A**
Eliza Llanes Sopena, **CPC-A**
Elizabeth Alfante, **CPC-A**
Elizabeth Bowling, **CPC-A**
Elizabeth Mathew, **CPC-A**
Ellen Lacey, **CPC-A**
Enu Arora, **CPC-A**
Erica Duckworth, **CPC-A**
Farhana Ferdous, **CPC-A**
Fathima Suhaima, **CPC-A**
Gail Binder, **CPC-A**
Gail King, **CPC-A**
Garima Mishra, **CPC-A**
Gaurav Kumar, **CPC-A**
Gayathiri Sambasivam, **CPC-A**
Geoffrey Huggins, **CPC-A**
Gerri Miller, **CPC-A**
Gina Lewis-Williams, **CPC-A**
Gobikannan Balu, **CPC-A**
Gowtham Ramasamy, **CPC-A**
Hailey Asher Halderman, **CPC-A**
Hannah Mailly, **CPC-A**
Harshala Kshirsagar, **CPC-A**
Holly Hollar, **CPC-A**
Irfan Ahmed, **CPC-A**
Jacqueline I Knight, **CPC-A**
Jacqueline Michelle Cleveland, **CPC-A**
Jacquelyn D Johnson, **CPC-A**
Jacquelyn T Rosario, **CPC-A**
Jagruti Ruparel, **CPC-A**
James Dunnick, **CPC-A**
Janet Cahill, **CPC-A**
Janet E Davis, **CPC-A**
Janice Gail Biederman, **CPC-A**
Jaqueline Kaufman, **CPC-A**
Jayashree Govindaraj, **CPC-A**
Jeanette Barth, **CPC-A**
Jeevan Jyothi Rekhala, **CPC-A**
Jennifer Breining, **CPC-A**
Jennifer Burgel, **CPC-A**
Jennifer Horner, **CPC-A**
Jennifer Olivares Dinges, **CPC-A**
Jennifer Schmutz, **CPC-A**
Jennifer Sell, **CPC-A**
Jessica Lamprey, **CPC-A**
Jessica Lynn Miller, **CPC-A**
Jill Lee, **CPC-A**
Joan Ferguson, **CPC-A**
Joanna Otero, **CPC-A**
Joanna Piotrowska, **CPC-A**
Jody L Holland, **CPC-A**
John Holladay, **CPC-H-A**
Jorge Alduenda, **CPC-A**
Joseph Bedford, **CPC-A**
Joshua Cronan, **CPC-A**
Joyce Anne Kilgore, **CPC-A**
Judith Pfutzenreuter, **CPC-A**
Judy Rose, **CPC-A**
Julia Castro, **CPC-A**
Julie Lovelace, **CPC-A**
June Tanner, **CPC-A**
Jyothi Gundu, **CPC-A**
Jyoti Dasharath Satyapal, **CPC-A**
Jyoti Singh, **CPC-A**
Kalluri Sivananda Reddy, **CPC-A**
Kannan Sekaran, **CPC-H-A**
Karen Bautista, **CPC-A**
Karen Fan, **CPC-A**
Karen Kuchler, **CPC-A**
Kari L Widdifield, **CPC-A**
Karnika Solanki, **CPC-A**
Karthika Omanakuttan, **CPC-A**
Kathleen Ann Heide, **CPC-A**
Kathleen Bryant, **CPC-A**
Kathleen Decipulo, **CPC-A**
Kathy Wroblewski, **CPC-A**
Katie Remitz, **CPC-A**
Katy Perez, **CPC-A**
Kaysi L Gominiak, **CPC-A**
Kelly Merritt, **CPC-A**
Kendra G Burns, **CPC-A**
Kenia Ledesma, **CPC-A**
Kenneth Matousek, **CPC-A**

Kim C Hines, **CPC-A**
Kim Charnley Dunn, **CPC-A**
Kim VanDine, **CPC-A**
Kim Vandiver, **CPC-A**
Kimberly Walker Davis, **CPC-A**
Kirit Patel, **CPC-A**
Kishor Harishchandra Pharad, **CPC-A**
Krishna Kumar Ganesan, **CPC-A**
Krishna Prabu, **CPC-A**
Kristen Patricca, **CPC-A**
Kristie Gavette, **CPC-A**
Kristie Tucker, **CPC-A**
Ksenia Coble, **CPC-A**
Kshama Narendra, **CPC-A**
Kuthuru Srikanth, **CPC-A**
Laura Giguere, **CPC-A**
Laura Korytkowska, **CPC-A**
Lauran Laurent, **CPC-A**
Lauren Boromei, **CPC-A**
Lauren Spears, **CPC-A**
Leda Silvera, **CPC-A**
Leigh Ziegler, **CPC-A**
Lijo Joy, **CPC-A**
Lillian Pohl, **CPC-A**
Linda Hall, **CPC-A**
Lindsay McCracken, **CPC-A**
Lisa Mansour, **CPC-A**
Lola Carter, **CPC-A**
Lori Eckhout, **CPC-A**
Lori Sekora, **CPC-A**
Lorri A Shelton, **CPC-A**
Lynn Byrum, **CPC-A**
M Rahul Santosh, **CPC-A**
M Kiran Kumar Goud, **CPC-A**
Mahesh Koppachari, CPC-A, **CPC-P-A**
Mandar Pralhad Desale, **CPC-A**
Manish Kumar, **CPC-A**
Manju Bhargavi Konkyana, **CPC-A**
Manpreet Singh Saluja, **CPC-A**
Mansi Parikh, **CPC-A**
Marcie M Baylor, **CPC-A**
Maria Koullick, **CPC-H-A**
Mark Clark, **CPC-A**
Mary E Paprocki, **CPC-A**
Maryann Wotton, **CPC-H-A**
Mayank Goel, **CPC-A**
Melissa Heydon, **CPC-A**
Melissa Anne Suhar, **CPC-A**
Melissa Landis, **CPC-H-A**
Melissa Ruiz, **CPC-A**
Melissa San Martin, **CPC-A**
Michael Centeno, **CPC-A**
Michele Alonso, **CPC-A**
Michelle L Stefanich, **CPC-A**
Michelle Leigh Dietterick, **CPC-A**
Mirza Baig, **CPC-A**
Mithila Dilip Kamble, **CPC-A**
Mohammad Azhar Hussain, CPC-A, **CPC-P-A**
Mohammed Abdul Wajid, **CPC-A**
Mohammed Nooruddin, **CPC-A**
Monika Verma, **CPC-A**
Morgan Lopez, **CPC-A**
Moses Tagayun, **CPC-A**
N Surya Prakash, **CPC-A**
Nancy Barnes, **CPC-A**
Narender Rana, **CPC-H-A**
Natalie Stowell, **CPC-A**
Navy Howard, **CPC-A**
Nayana Laxman Patil, **CPC-A**
Neha Dixit, **CPC-A**
Neysa M Luckado, **CPC-A**
NIthya Jayaseeli Alponse Antony Dasan, **CPC-A**
Nupur Vasani, **CPC-A**
Olga Lizarraga, **CPC-A**
Padma Gunji, **CPC-H-A**
Pallavi Desai, **CPC-A**
Pam Pecero, **CPC-A**
Pamela Bingham, **CPC-A**
Pamela Wilson, **CPC-A**
Pankaj Sarkar, **CPC-A**
Papia Ghosh Hazra, **CPC-H-A**
Patria Barnes, **CPC-A**
Patricia C Trevillian, **CPC-A**
Patricia Colomina, **CPC-A**
Patricia Kay Mangus, **CPC-A**
Patty Olsen, **CPC-A**
Paula Akalis, **CPC-A**
Pearl Ferguson, **CPC-A**
Penny Jones, **CPC-A**
Pragati AS Tiwari, **CPC-A**
Puneet Dwivedi, **CPC-A**
Rachael L Montgomery, **CPC-A**
Rachel Hoffman, **CPC-H-A**
Rachel Jordan, **CPC-A**
Rachel Montejano, **CPC-A**
Rachel Phillips, **CPC-A**
Raghu Tandrapati, **CPC-A**
Rajendar Gunreddy, **CPC-A**
Rajesh Kannan Seeniappan, **CPC-A**
Ramarajan Ramasamy, **CPC-A**
Ramona E Turner, **CPC-H-A**
Ranjithkumar Subramanian, **CPC-A**
Rayetta Dishon, **CPC-A**
Rebecca Rutherford, **CPC-A**
Renee Denise Rawlings, **CPC-A**
Renee Kyle, **CPC-A**
Renjini Ramabhadran, **CPC-H-A**
Resham Kaur Sethi, **CPC-A**
Ricardo Gomez, **CPC-A**
Robin B Gray, **CPC-A**
Rochelle Meneses, **CPC-A**
Rosario Canete, **CPC-A**
Rosemary Hart, **CPC-A**
Roxana Bejinariu, **CPC-A**
Roxanne L Hitchcock, **CPC-A**
Ruthann Coulson, **CPC-A**
Ryan Moat, **CPC-A**
Ryne Davis, **CPC-A**
Sachin Agnihotri, **CPC-A**
Sagunthala Govindaram, **CPC-A**
Sally Jo Harvey, **CPC-H-A**
Samantha Payne, **CPC-A**
Sampath Kumar, **CPC-A**
Samreen Naz, **CPC-A**
Samukele Siziba, **CPC-H-A**
Sandra Perth, **CPC-A**
Sandra Pompey, **CPC-A**
Sandra Smith, **CPC-A**
Sandy Lo, **CPC-A**
Saniya Abraham, **CPC-A**
Saptagiri Palleti, **CPC-A**
Sarah Danielle Fabela, **CPC-A**
Sarah Sires, **CPC-A**
Sarah Tayloe, **CPC-H-A**
Saranya Sivakumar, **CPC-A**
Saranya Viswanathan, **CPC-A**
Saravana P Kumar, **CPC-A**
Saravanan Jagadeesan, **CPC-A**
Saurabh Sharma, **CPC-A**
Sayeh Kerney, **CPC-A**
Seba Sainvilus, **CPC-A**
Shaik Abbu Baker, **CPC-A**
Shankar Mariyappan, **CPC-A**
Shankrelyn Combs, **CPC-A**
Shannon Orton, **CPC-A**
Sharon Schneider, **CPC-H-A**
Sheila Betancourt, **CPC-A**
Sheila Vanderlin, **CPC-A**
Sherri Nixon, **CPC-A**
Sheryl Kay Appleby, **CPC-A**
Shilpa Uday Takke, **CPC-A**
Shiva Prasad S, **CPC-A**
Shubhangi Suresh Pawar, **CPC-A**
Shweta Kotian, **CPC-A**
Shyam Sundar R, **CPC-H-A**
Silvia Millner, **CPC-A**
Siva Sugumar, **CPC-A**
Sivaiah Lanke, **CPC-A**
Sonali Ashok Todke, **CPC-A**
Soumyadipta Das, **CPC-H-A**
Sravanthi Karna, **CPC-A**
Sreedhar Badam, **CPC-A**
Srikanth Bingi, **CPC-A**
Srimadhuri Kattoju, **CPC-A**
Srimathi Srinivasan, **CPC-A**
Stephanie Danielle Seagroves, **CPC-A**
Stephanie Freeman, **CPC-A**
Stephanie Johnson, **CPC-H-A**
Stephanie Tibaduiza, **CPC-A**
Stephanie Tice, **CPC-A**
Stephen Hetu, **CPC-H-A**
Sujata Sadashiv Pawar, **CPC-A**
Suman Pinddi, **CPC-A**
Surjeet Bisht, **CPC-A**
Susan Holler, **CPC-A**
Susan Bowman, **CPC-A**
Susan Krepshaw, **CPC-A**
Susan Marquerite Moslak, **CPC-A**
Susie Verdier, **CPC-A**
Suvish Sadanandan Theepuka, **CPC-A**
Swagath Kumar, **CPC-A**
Swati Gupta, **CPC-A**
Sweta Vadalia, **CPC-A**
Tameka Denmark, **CPC-A**
Tanisha DeVore, **CPC-H-A**
Tanu Makkar, **CPC-A**
Tara Fillmore, **CPC-A**
Tarun Kumar Bais, **CPC-A**
Taylor Hyde, **CPC-A**
Teeja Mariamma Alexander, **CPC-A**
Tennile Tetreault, **CPC-A**
Teresa Diane Phillips, **CPC-A**
Teresa Jones, **CPC-A**
Teresa M Sanchez, **CPC-A**
Terri Yearby, **CPC-A**
Theresa Boatman, **CPC-A**
Thong Vang, **CPC-A**
Tracy Rodgers, **CPC-A**
Travis Dixon, **CPC-A**
Trista Stephens, **CPC-A**
Trudy Woosley, **CPC-A**
Usha Shetty, **CPC-A**
Venu Pawar, **CPC-H-A**
Vijay Baskar, **CPC-A**
Vikas Chawla, **CPC-A**
Vikas Chhabra, **CPC-A**
Vinay Kumar Palnati, **CPC-A**
Vishnuvardhan Reddy Rammohan, **CPC-A**
Vivek Kumar Singh, **CPC-A**
Vivian Ayoub, **CPC-A**
Wasi Ahmed, **CPC-A**
Weijia Liu, **CPC-A**
Wendy Frye, **CPC-A**
Wendy Rangel, **CPC-A**
Wendy Renee Ramirez, **CPC-H-A**
Whitney Vance, **CPC-A**
Whitney Wysong, **CPC-A**
Yadira Perez, **CPC-A**

Specialties

Alina Mattila, **CEMC**
Alison Bossie, CPC-A, **CPPM**
Alka Tyagi, CPC, **CPMA**
Amy S Baker, CPC, CPMA, **CPPM**
Andrew Montaruli, CPC, CPMA, CPPM, **CEDC**, CEMC
Angela K Bihm, CPC, **CPMA**
Ann Nelms, CPC, **CPPM**
Anne Pickel, **CPCO**
April Clayton, CPC, **CHONC**
Arverla R Neal, CPC, CPMA, **CEMC**
Brenda L Emrick, CPC-H, **CEDC**
Carissa Morgan Foster, CPC, **CEMC**
Casey Drake, CPC, **CFPC**
Cathy English, **CPMA**
Cathy Hill, CPC, **CPPM**
Cathy Thebeau, CPC, CPMA, CFPC, **CIMC**
Charlotte Kathleen Davis, CPC, **CPCO**
Crisleyla Sliman, CPC, **CGSC**
Crystal Conradson, CPC, **CEMC**
Danaysi Parla, **CPEDC**
Debra L Miller, CPC, **CEMC**
DeeDee Lambeth Culler, CPC, **CEMC**
Denise B Gregory, CPC, **CPPM**
Dorice Millar, **CPPM**
Emily Vinson, **CPCD**
Erin Marie Jones, CPC, **CPMA**
Ethel Triche, CPC, **CEMC**
Faye Taylor, **CASCC**
Gena L Rooney, CPC, **CPCO**, CPC-P, CPMA
Ginger Parker, CPC, **CPMA**
Heather Lea Bowens, CPC, **CEMC**
Heather Marie Allen, CPC-H, **CPMA**
Iwalani Paquette, CPC, **CPPM**
Jane F Elliott, CPC, **CPMA**
Jennifer Osterman, **CEMC**
Jesse Suphan, **CPMA**
JoAnne M Sheehan, CPC, **CPPM**, CPC-I
Jodi Anne Centko, CPC, **CEMC**
Judith Konstans, CPC, **CPMA**, CEMC
Kara Elizabeth Pedigo, CPC, **CEMC**
Karen Chappell, **CIRCC**
Karen Lavigne, CPC, **CPMA**
Kathleen A Enniss, CPC, **CPMA**
Kathlene Brown, **CPPM**
Katrina Tweedy, CPC, **CPMA**
Kristen Marcotte, **CEMC**
LaShonda White, **CPMA**
Laurie Wright, **CPPM**
Lisa Chaillier, **CEMC**
Lisley Lopez, CPC, CPC-H, **CPMA**
Lori Stutler, **CPPM**
Lynn Roberson, CPC, **COBGC**
Margie Speight, CPC, **CPMA**
Michael Nomura, CPC, CPC-H, CPC-P, CANPC, CEDC, **CEMC**
Michael Westover, **CPMA**
Michele Steward, **CEMC**, CUC
Michelle Qualls, **CPCD**
Miki L Jay, CPC, **CCC**
Mohammed Yaseen Mohiuddin, CPC, CPC-P, **CPMA**
Nerissa Tucker, CPC, **CHONC**
Nikole Filz, **CPCD**
Olga Barkalova, **CPPM**
Pamela A Kozlowski, CPC, **CEMC**
Patsy Baker, CPC, **COBGC**
Paul Specker, **CEMC**
Pramod Kanhaiyalal Gupta, CPC, **CIRCC**
Pushpalata Phapale, CPC-A, **CIRCC**
Rafael Abreu, CPC, CPC-H, **CPMA**
Reddy Swamy Ranga Reddy, CPC-P-A, **CPMA**
Sandra Sperrazza, CPC, CPMA, **CANPC**
Santosh Kumar Meriyala, CPC, CPC-H, CPC-P, CPMA, **CEMC**, CFPC, **CIMC**
Sara Grimm, **CPCD**
Sharon Kasica, **CPCO**
Sheena Shytle, CPC, **CCC**
Sheila Erwin, CPC, **CPPM**
Sonia M Bennett, CPC, **CIMC**
Sonia M Magliocchetti, CPC, CPMA, **CEMC**
Stacy Galloway, **CFPC**
Steven Stocki, **CPCO**
Susan Burke, CPC, **CEMC**
Susan Faust, **CPPM**
Susan M Achenbach, CPC, **CPMA**
Suzanne Becker, CPC, **CEDC**
Tangela L Smith, CPC, **CANPC**
Tanya Sharpe, CPC, **CCC**
Tanya Walls, CPC, **CPMA**
Taryn Danise Schraad, **CPMA**
Tawnya M Priego, CPC, **CEMC**
Terri E Scott, CPC, **CASCC**
Tina G Kaack, CPC, **CEMC**
Tracey Ceravino, **CPPM**
Tracey Grant, **CEDC**
Vanessa Lorraine Moldovan, CPC, **CPPM**
Veronique Van Hoof, CPC, **CASCC**
Wendy Rautio, **CEMC**

Magna Cum Laude

Danay Cosme, **CPC-A**
Dorothy McIntosh, **CPC-A**
Jill E Kulanko, **CPC**, CPC-H, CPC-I
Kimberly Hale, CPC-H, **CASCC**
Melissa Haag, **CPMA**
Paula Jensen, **CPC-A**
Radhakrishnan Annamalai, CPC, CPC-H, **CANPC**
Susan Richards, **CPC**
Tabitha Lugg, **CPC**

A&P Quiz

(from page 15)

Answer: The correct answer is C. The calcaneus is the quadrangular bone at the back of the talus.

Peggy Chancellor, CPC

Coding Specialist II, Texas Children's Hospital

1. Tell us about your career—how you got into coding, what you've done during your coding career, what you're doing now, etc.

My career started in 1974, working for oral and maxillofacial surgeons. I started as a surgical assistant and transitioned to an administrative assistant in 1979. I worked for 25 years in the oral and maxillofacial specialty, and my responsibilities changed from clinical to administrative (insurance). I learned a lot about both medical and dental coding and terminology.

I made a decision to learn more, expand my horizons, and become a Certified Professional Coder (CPC®). I studied for three months and was pleased to pass the exam on the first try.

I was hired by Baylor College of Medicine in 2009 to help implement dental billing for Texas Children's Hospital physicians. In June 2009, Texas Children's Physician Services Organization (TCPSO) was transitioned to employees of Texas Children's Hospital. TCPSO is responsible for coding and billing for over 900 physicians who work for Texas Children's Hospital.

In 2011, I transferred to the coding department. I code for hematology—oncology and chemotherapy. I review physician/provider attestations for key elements of documentation, ensuring coding guidelines are met. I also code emergency services.

This year, I am on the TCPSO staff council and a liaison representative for the Revenue Education Cycle Team's coding department for an Epic update being implemented in July 2013.

2. What is your involvement with your local AAPC chapter?

I started attending Houston, Texas, local chapter meetings when I received my CPC®. In 2011, I served as secretary/treasurer; and in 2012, I served as treasurer. I've proctored exams, helped with review classes, recorded meeting minutes, completed quarterly reports, maintained sign-in sheets, sent out job announcements, and helped plan and organize the annual 2010 banquet and the annual symposium.

Getting involved in my local chapter definitely advanced my coding career. Serving as an officer let my supervisors know I was serious about my career. Volunteering my time for others made me feel good about myself. I tried hard to help members feel welcome at meetings and to be pleasant and friendly, with a "Good morning and good luck!" welcome to those coming to take their exams. My involvement in my chapter has been very rewarding and a great learning experience.

3. What AAPC benefits do you like the most?

I mostly like being a part of an organization that maintains high standards, ethics, professionalism, and excellent continuing education. I also like AAPC's opportunity to advance members' careers through additional certifications.

4. What has been your biggest challenge as a coder?

The biggest challenge is for new members. There should be a better way for new coders to find employment in this field. There are many coding jobs in the employment market, but most job descriptions state two years' coding experience is necessary, which makes it difficult for new coders to get established. Apprenticeships, volunteering, or partnerships with large medical organizations are a few ways new coders can transition into coding positions, but these opportunities can be hard to come by. I was lucky to be in the right place at the right time with the right certification.

5. How is your organization preparing for ICD-10?

Texas Children's Hospital and TCPSO are preparing for ICD-10-CM in all aspects. We have already starting implementing IT and business (administration, training, crosswalk documentation, and payer transaction/testing) readiness.

This includes training for all physicians, nurses, coders, managers, ancillary staff, laboratory, and cardiology catheter labs. Our coding department is taking AAPC's online ICD-10-CM Anatomy and Pathophysiology modules. I am fortunate to work for an organization that stays ahead of the curve, providing the tools necessary for this next phase in coding.

6. If you could do any other job, what would it be?

I would have liked to be an artist or musician. They have a true gift. Since I am not inclined in either, I am happy with my coding career and the opportunities ahead.

7. How do you like to spend your spare time?

I have been married to Dewayne for 33 years. We have a daughter, Allison, who attends the University of Houston and is completing her degree in psychology. I am from a large family and enjoy spending time with them. We love going to Texas Hill Country (most of my family lives in Austin) and spending time at Lake Buchanan or Port Aransas. I also love to read, travel, and shop.

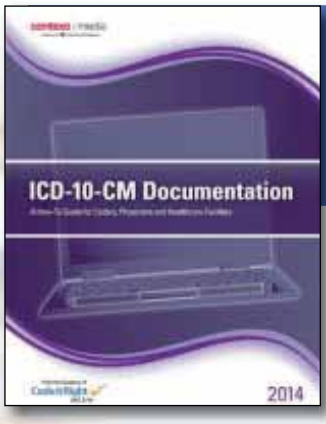
2014 ICD-10 Documentation:
A How-To Guide for Coders, Physicians and Healthcare Facilities

Understanding the new documentation requirements for ICD-10-CM is vital for a smooth transition to the ICD-10 coding set. ICD-10-CM requires much greater detail in order to assign specific codes. Prepare yourself with the 2014 ICD-10-CM Documentation: A How-To Guide for Coders, Physicians and Healthcare Facilities today.

The 2014 edition of this indispensible resource identifies all of the additional ICD-10-CM documentation requirements with detailed checklists, extensive coding examples and a new appendix defining key terms with identifying icons.

Some key features of this essential book include:

- **A comprehensive review of each ICD-9-CM chapter** with every corresponding ICD-10-CM chapter(s), with all diagnoses and/or conditions requiring additional documentation, and a detailed discussion of all relevant coding guidelines and notes
- **An ICD-9-CM and ICD-10-CM side by side comparison** of code categories and subcategories that require more specific documentation, including elements such as more specific site or body part descriptions, new designations for lymphomas and other blood cancers, and episode care for injuries, poisoning and other external causes
- **A table showing ICD-9-CM codes** and new ICD-10 codes for the same common conditions
- **Checklists** to identify the new documentation elements for categories, subcategories and/or codes in ICD-10-CM
- **Extensive checklists** to identify the new documentation elements for categories, subcategories and/or specific codes in ICD-10-CM
- **Examples of common scenarios** showing requiring documentation in ICD-9-CM and ICD-10-CM with the additional necessary documentation elements highlighted
- **End of chapter quizzes** allowing you to test your knowledge, including coding practice for the conditions discussed
- **Specialty-specific checklists** to help you review current records and identify all documentation deficiencies



ITEM ID: DBP-14

Regular Price: $159.95

Your Price: $127.96

You save 20% if you order onsite!

Better together: 2014 ICD-10 Anatomy and Documentation Book Bundle

A more thorough understanding of anatomy and physiology is required for this new code set. Be prepared with the 2014 Advanced Anatomy and Physiology for ICD-10-CM/PCS.

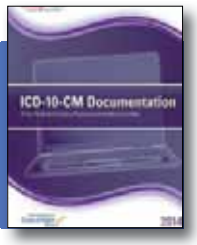
Buy both books in a bundle and save!

ITEM ID: I10BUNDLED-14

Regular Price: $288

Your Price: $230.40

You save 20% if you order onsite!



2014 CODE BOOKS

Lowest Prices Anywhere

Pre-Order Sale Ends June 30th

Last Month to SAVE!

Bundles

	*Our Best Value!* *Physician Bundle 3* ICD-9 1 & 2 • HCPCS • Procedural Coding Expert	$269.95 **$99.95**
	*Physician Bundle 1* ICD-9 1 & 2 • CPT® • HCPCS Level II	~~$299.95~~ **$159.95**
	*Hospital Bundle 1* ICD-9 1-3 • CPT® • HCPCS Level II	~~$309.95~~ **$169.95**
	*Physician Bundle 2* ICD-9 1 & 2 • HCPCS • CPT® • Procedural Coding Expert	~~$399.95~~ **$199.95**
	*Hospital Bundle 2* ICD-9 1-3 • HCPCS • CPT® • Procedural Coding Expert	~~$409.95~~ **$209.95**

BONUS: Add an ICD-10 Book to any 2014 bundle for only ~~$89.95~~ $49.95

Individual Books

ICD-9-CM Vol. 1-2

~~$99.95~~ **$44.95**

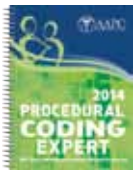
ICD-9-CM Vol. 1-3

~~$103.95~~ **$54.95**

HCPCS Level II

~~$99.95~~ **$44.95**

Procedural Coding Expert



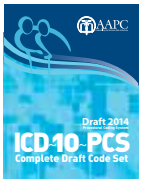
~~$99.95~~ **$54.95**

AMA's CPT® Professional

~~$114.95~~ **$89.95**

ICD-10

ICD-10-PCS



~~$99.95~~ **$59.95**

ICD-10-CM

~~$99.95~~ **$59.95**

AAPC

Pre-order Today!
www.aapc.com/2014codebooks
1-800-626-CODE (2633)