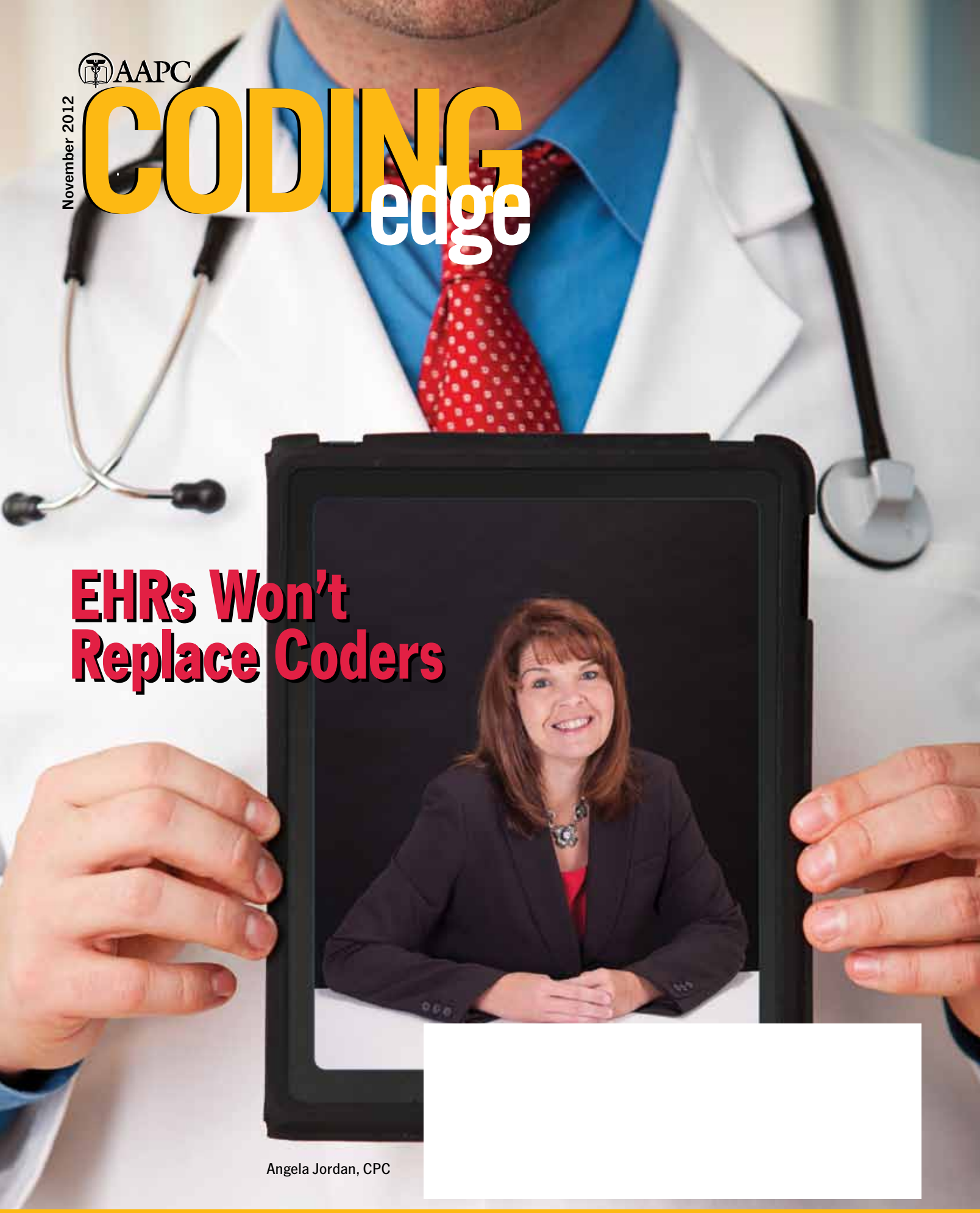
AAPC
November 2012

CODING edge



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Angela Jordan, CPC

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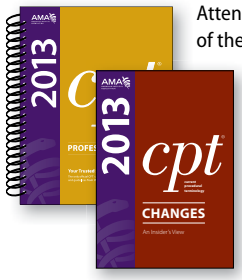

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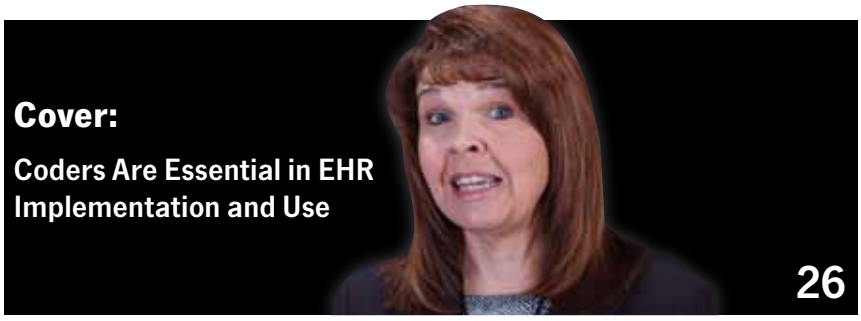

Cover:
Coders Are Essential in EHR Implementation and Use
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Features

On the Cover: *Angela Jordan, CPC, embraces electronic health record technology and proves coders are essential to a smooth transition. Ms. Jordan's portrait is by Denny Medley (www.randomphotograpy.com).*

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November 2012

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Physicians Should Control Health Care

I read an interesting survey published Sept. 24 by The Physicians Foundation (www.physiciansfoundation.org/news/press-releases). The results of this survey of more than 13,000 physicians really caught my attention:

1. Physicians are working fewer hours, seeing fewer patients, and limiting access to their practices.
2. If these patterns continue, we will effectively lose 44,000 full-time-equivalent physicians.
3. In the next three years, 50 percent of physicians plan to cut back on the number of patients seen, work part time, switch to concierge medicine, retire, or take other steps to reduce patient access.
4. Assuming that perhaps as many as 100,000 physicians will move from practice-owner status to employed status with large facilities, this will lead to 91 million fewer patient encounters.
5. With health care reform adding between 20 to 30 million new patients to the system, there is deep reason to believe access to care will become a critical problem.

Trends Spiral Toward Costs and Uncertainty

Eighty percent of the physicians who responded to the survey cited "patient relationship" as the most satisfying part of their job; while interestingly 52 percent said they have limited health care access to Medicare patients or are planning to limit it. Twenty-five percent have closed their practice to Medicaid patients. Liability/defensive medicine pressures related to potential lawsuits, Medicare/Medicaid government regulations, reimbursement (sometimes perceived) reductions, and the uncertain future of health care were cited as some of the reasons for discontent.

"The level of pessimism among America's physicians is troubling," said Lou Goodman, PhD, president of The Physician Foundation and CEO of the Texas Medical Association, responding to the survey.

As we all know, the cost of health care is a major problem. Physicians believe defensive medicine, which causes too many tests and procedures to be performed, our aging population, cost of drugs, advances in technology and treatments, and social conditions (lifestyle choices causing poor health) are the primary causes of unnecessary costs.

The survey also noted that an incredible 92 percent of physicians are unsure where the health system will be or how they will fit into it in five years. Sixty-two percent believe that accountable care organizations (ACOs) are either unlikely to increase quality of care and decrease costs, or any gains will not be worth the resources and effort. Lastly, 47 percent have significant concerns that electronic health record systems pose a risk to patient privacy.

More Physician Action & Less Government Action

America does not have a health care system without physicians. Physicians have acquired valuable skills through many years of expensive education and training, and should make very good livings. The survey said that 82 percent of physicians believe they have little ability to change the system, but I believe they do. It's almost like they are sitting at a poker table with four Aces in their hand and folding. Physicians can do more to insert themselves into the game, though it may take short term sacrifice to be successful.

Now for the controversial part: I have yet to see a program from the federal government that has made something cheaper. If it does hold costs down (for example, the postal system and Amtrak), it does so with subsidies from general funds. Government is inherently inefficient and the more government gets involved with health care, the more physicians will be dissatisfied, the less access patients will have to care, and the higher the cost will be. I believe we should allow:

- payers to sell across all state lines;

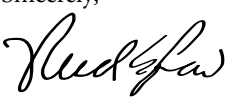
- patients to get their insurance from whomever they want with reduced premiums and higher deductibles so we all know the actual cost of the care (similar to home and auto insurance);
- standardization of the billing procedures; and
- tort reform so physicians can advise the patient of risks, and then a joint decision between only physician and patient (not payer) can be made on what to do.

These steps will help reduce costs and increase quality of care.

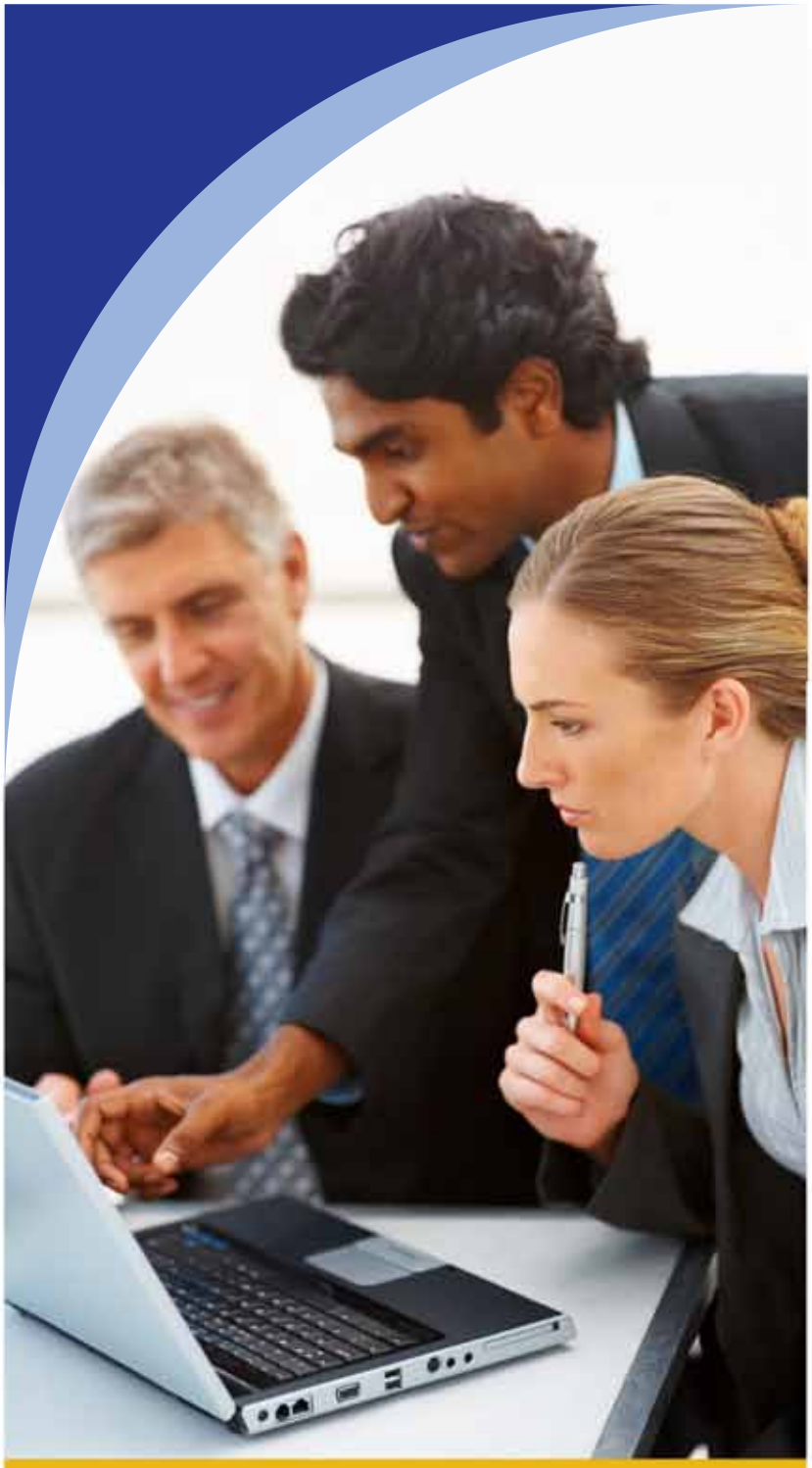
Leave Health Decisions to the Provider

More paperwork does not increase clinical quality and more liability concern does not reduce costs. Advances in clinical technology should make health care not only better but more efficient and cost effective. I'm confident that happy physicians will make for a far better health care system. They are smart enough to figure it out.

Sincerely,



Reed E. Pew
AAPC President and CEO



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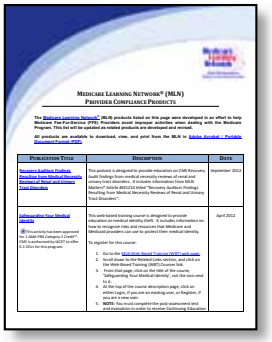

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Recovery Auditors Produce Findings from Medical Necessity Reviews of Renal and Urinary Tract Disorders	This product is designed to provide education on CMS Recovery Audit findings from medical necessity reviews of renal and urinary tract disorders. It includes information from MLN Matters® Article #SE1210 titled "Recovery Auditors Findings from Medical Necessity Medical Necessity Reviews of Renal and Urinary Tract Disorders."	September 2012
Safeguarding Your Medical Identity	This web-based training course is designed to provide Medicare beneficiaries with basic, easy-to-use information on how to recognize risks and measures that Medicare and Medicaid providers can use to protect their medical identity. To register for this course: 1. Go to the MLN Web-Based Training (WBT) web page. 2. Scroll down to the Related Links section, and click on the Provider Compliance Training WBT. 3. From the page, click on the title of the course, "Safeguarding Your Medical Identity", not the icon next to it. 4. At the top of the course description page, click on "Register". If you are an existing user, on Register, if you are a new user. 5. NOTE: You must complete the post-assessment test and evaluation in order to receive Continuing Education	April 2012

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Manage Holiday Spending and Value in Health Care

In anticipation of the holiday season, I have begun making a list of gift wishes for the loved ones in my life, young and old. The current, uncertain economy and predicted cost, however, causes me to shudder at the thought of fulfilling all of those wishes. But the anticipated smiles make it all worth it.

Although I dread the hassle of Black Friday's sales crowds, I dutifully scour through the advertisements each season plotting my strategy for obtaining the lowest prices in the shortest amount of time. Each year, the crowds seem to get larger, with shoppers on the holiday hunt for the best bargains to leverage the value of every dollar in their wallets. I feel victorious when leaving the cold and crowds behind with my packages in tow.

Beat the Crowds and Save a Buck Online

The new alternative to chaotic Black Friday shopping is "Cyber Monday," which is gaining the interest of consumers each year, including myself. If you're one of the growing number of cyber shoppers, look into your AAPC Member Perks, located when you click on the "Savings" link on the "Resources" tab of the AAPC homepage (www.aapc.com/resources/member-benefits.aspx). There you can find additional savings at more than 300 locations including, Target, Kohl's, Sears, and Barnes & Noble.

Getting the Most Bang for Your Buck in Health Care

The quest for leveraging dollar value is becoming common in every aspect of our lives today, both personal and professional. Physicians and health care entities are consistently looking for ways to raise revenue and reduce practice expense. One way to cut practice expense will involve finding and utilizing staff with proven knowledge and skills to fulfill multiple and varied tasks within the practice; for example, a practice manager who is also a compliance officer, or a coder who assists in payer contract negotiations.

Gain Leverage and Build Professional Status

Working in health care today is about leveraging your knowledge, skills, and experience, as well. Take a good look at your current credentials and ask yourself these questions:

- Do I have the right balance of credentials to provide what an employer needs in today's market?
- Do I stand out as a complete package to my current or future employer?
- Is there an area or task at my office that can be accomplished only through the skills, knowledge, or experience I have?

If your answer to any or all of these questions is a resounding "YES!", then you are on your way to successfully leveraging your career in the future of health care. If not, it's not too late to build on your present professional status. By adding just the right mix of credentials to your portfolio, you'll enhance and affirm your employer appeal now and into health care's future.

Best Wishes,

Cynthia L. Stewart

Cynthia Stewart,
CPC, CPC-H, CPMA, CPC-I, CCS-P
President, National Advisory Board

Letters to the Editor

Please send your letters to the editor to:
letterstotheeditor@aapc.com

Look to G codes for Medicare Drug Screens

The September 2012 article "Code for Qualitative vs. Quantitative Drug Testing" (Quick Tips, page 10) did not mention that Medicare does not accept either 80100 *Drug screen, qualitative; multiple drug classes chromatographic method, each procedure* or 80101 *Drug screen, qualitative; single drug class method (eg, immunoassay, enzyme assay), each drug class*. Instead, use G0431 *Drug screen, qualitative; multiple drug classes by high complexity test method (eg, immunoassay, enzyme assay), per patient encounter* and G0434 *Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter*. For additional instructions, see MLN Matters® SE1105 Revised (**www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1105.pdf**).

Medicare has limited conditions considered medically necessary for these codes; coders should review their fiscal intermediary (FI)/carrier/Medicare administrative contractor (MAC) local coverage determinations (LCDs) for specific guidance.

Phyllis Yang-Cashman, CPC-A

Clarification: Modifier 78, not 58, Requires a Return to the Procedure/Operating Room

The article "Choose Which to Use: Modifiers 58, 78, or 79?" (September 2012 *Coding Edge*, pages 18-20) contained the statement, "Note that Medicare requires a return to the operating room (OR) to apply modifier 58, 'unless the patient's condition was so critical there would be insufficient time for transport.'"

In fact, the above guideline applies to modifier 78 *Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period* rather than modifier 58 *Staged or related procedure or service by the same physician during the postoperative period*.

Per the American Medical Association's (AMA's) *CPT® Changes 2008: An Insider's View*:

"Modifier 78... It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure."

The Centers for Medicare & Medicaid Services (CMS) applies the same rule, per the *Medicare Claims Processing Manual*, chapter 12, section 40.2:

"The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier '-78' to the related procedure."

CMS defines an OR "as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)."

As stipulated in the article, modifier 78 applies when a return to the OR is unplanned (e.g., in case of complication); whereas, modifier 58 applies when a procedure is: A. Planned prospectively or at the time of the original procedure; B. More extensive than the original procedure; or, C. For therapy following a diagnostic surgical procedure.

Used with Caution, Templates Can Be Compliant

The article "Create Order from Wellness Visit Chaos" by Jacqueline Nash Bloink, MBA, CHC, CPC-I, (August 2012 *Coding Edge*, pages 16-17) advises providers to use a single template to document the welcome to Medicare exam (G0402 *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*), initial annual wellness visit (G0438 *Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit*), and subsequent annual wellness visits (G0439 *Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit*), although the requirements for each of these exams differ. In the current climate of heightened awareness concerning the use of documentation templates (particularly with regard to electronic health records (EHRs)), this recommendation raises a few concerns:

1. The Centers for Medicare & Medicaid Services' (CMS) *Evaluation and Management Services Guide* states that services must be, "Furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition (i.e., not provided mainly for the convenience of the beneficiary, provider, or supplier)..." In light of these instructions, should a provider render services based on a documentation template, rather than render the appropriate service and document and bill based on that service?
2. Coders are under increasing pressure to be more efficient and productive. If they see the same documentation for three different types of preventive visits, more time and effort will be required to determine which preventive code(s) to bill. Coding won't necessarily be based on the services rendered and documented if the documentation is the same for all preventive services.
3. Using a single preventive services template will result in the provision of some services that will not be reimbursed. Is it the best use of practice resources for physicians and support staff to provide services for which they will not be reimbursed?

Payers expect provided services to be reasonable and necessary and for this to be reflected in the documentation; as such, I caution the use of "one size fits all" documentation templates.

Julie A. Leu, CPC, CPCO, CPMA, CPC-I

Ms. Leu raises excellent points, and her concerns are well founded. I agree that services provided should be driven by medical necessity. In the specific case of Medicare wellness exams G0402, G0438, and G0439, however, I believe that a single documentation template may be appropriate. In response to each of the above points:

1. The Medicare wellness visit(s) *are* templates, and the required components for each visit type are listed in many CMS articles. The "10 Easy Steps" recommended in the article simply combines the required components into a "master" template.
2. Regardless of whether the common template is used, code selection is based on patient status: New to Medicare (G0402); receiving a one-time-only initial wellness visit (G0438), or; receiving a subsequent yearly wellness visit (G0439).
3. Using a common template for the various Medicare wellness visits saves time by eliminating confusion over what services to provide at each visit type. And keep in mind: If the physician forgets a required component, the entire visit is non-payable under CMS guidelines. The minimal time investment to provide "additional" services may also improve patient satisfaction, and no overcoding will result.

I would not, however, discourage a physician office from creating separate templates for each of the wellness exams.

Jacqueline Nash Bloink, MBA, CHC, CPC-I

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By Wendy Grant, CPC

Surefire Testing Tips for Certification

Keep your nerves intact by preparing yourself for the big day.

Open book tests are not necessarily easy, and AAPC's certification exams prove it. You must know how to find coding information when you need it. Because you can't possibly memorize every single CPT®, HCPCS Level II, and ICD-9-CM code, you need to be knowledgeable and organized, conscientious of time, and able to use the process of elimination with efficiency. To hone these very important skills and help you pass your next exam with flying colors, we have some great test-taking tips, based on information collected from exam review class teachers in local chapters.

Manage Your Time

Watch the time. You have five hours and 40 minutes to complete the 150-question exam. Don't wait until five hours have passed before you look at the clock, and realize you have only answered half of the questions. Pace yourself.

Read All Questions Carefully

As you read through each question, circle or highlight the important words that will help you. Words for surgery such as "open," "closed," and "scope" will identify the approach used by the surgeon. Words such as "repair," "excision," and "incision" will show you what the surgeon intends to accomplish. Identify the body system, organ, or site for each operative note question. Read all of the choices before choosing an answer.

Answer the Easy Ones First

Be strategic when answering questions: Answer the easier questions first to build your confidence. There may be some questions you can answer without even opening your codebooks. Go through all of the questions, and answer those you know without hesitation; then, circle back around and begin working on the ones that require more thought.

Keep Your Eyes on the Grid

If you skip a question, make sure to skip it on the answer grid. Your answers could easily get out of sync if you aren't careful.

Eliminate the Obvious

You may discover a question that has two obviously wrong choices, but you cannot decide between the remaining two options or you might answer a question hesitantly. When you can't make a choice, eliminate the obvious incorrect answers in the booklet and then move on. You may find information further on that will turn on a light bulb for you. Mark unanswered questions or questions you think you may have answered incorrectly, with an asterisk (*) in the booklet so you can go back to them later if there is time.

Make Page Flipping Easier

Your code books will take a beating during the exam. The importance of knowing where to find everything cannot be stressed too much. If your books are not indexed, make your own tabs for classifications. Your coding materials should be as user-friendly as possible so you don't lose time locating what you need. Sometimes making your own written outline of the classifications can reinforce the structure of the books in your mind. Coders who are not familiar with the layout of their code books are not likely to finish the exam on time.

At first glance of the four multiple choice answers, identify which sections you'll need to use and only flip to each section once for that question. For example, given the following multiple choice answers, you should turn to the Evaluation and Management Services section one time and to the Surgery section one time:

A. 99212, 30905

B. 99213, 30901

C. 99212, 30901

D. 99213, 30903

Don't waste precious time flipping back to a page that you have already looked at for the same question. Time is your enemy; always make the best use of it whenever possible.

Make brief, written notes in the test booklet as you research each code in a section of your book. For instance, you might write these words beside the surgical procedures:

A. 99212, 30905 *posterior*

B. 99213, 30901 *simple*

C. 99212, 30901

D. 99213, 30903 *anterior*

This enables you to look once in the Evaluation and Management Services section, analyze the elements, and find the necessary clues for the surgery choices without having to flip back to the Surgery section. Decide which answer best fits the question and move on. You can use this same process for looking up diagnosis codes or HCPCS Level II codes.

Get to the Meat of the Matter

The operative notes you will be asked to code have information at the beginning and end you may be able to skim over. For instance, at the beginning of most op notes there is a sentence or two about positioning the patient on the table and prepping the site. At the end, there is usually a sentence or two regarding the closure of the wound, type of suture used, etc. In most cases, this information will not help you with the coding process. Get to the meat of the matter by starting your search where the surgeon is making the incision and stopping where the wound closure is described.

Take a Final Look

After you have answered all of the questions you could the first time through, go back and review or try to answer the questions you marked with an asterisk. If you still have time, review the answer grid to ensure you have answered all of the questions in the right order. If you changed an answer, make sure your final decision is well marked. CE

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. Ms. Grant has been on the AAPCCA Board of Directors since 2009 and served as secretary in 2011. She has been certified since 2002.

By Wendy Grant, CPC

Qualify for Chapter of the Year

Racking up Brownie points is easier than you may think.

Would you love your local chapter to be the next AAPC Chapter of the Year? If you don't think you have a shot, think again. Your chapter is probably already meeting most of these basic requirements:

- Host at least six meetings a year where continuing education units (CEUs) are offered.
- Submit chapter minutes for all meetings.
- Schedule and proctor at least four exams.
- Submit required paperwork on time for Election Verification Information (Nov. 30), Profit and Loss Statement (Jan. 15), and Quarterly Meeting Reimbursement Requests.
- Participate in training and mentoring your new officers.
- Display positive and professional attitudes at all times.

The items without points are things every chapter must do to qualify for Chapter of the Year. Beyond that, the chapter with the most points wins.

Here are some ways you may earn points to put your chapter "over the top:"

- Schedule and proctor more than four exams (30 points each)
- Sponsor a local chapter seminar (25 points)
- Participate in May MAYnia (25 points)
- Recruit new AAPC members (25 points)
- Hold a review class (25 points)
- Hold more than the six required meetings offering CEUs (20 points)
- Participate in Project AAPC (20 points)
- Represent your chapter at AAPC national or regional conferences (10 points)
- Participate in G2KYLC at conference (10 points)
- Mentoring program (25 points)

There are many other ways to make your chapter shine. Use your own creative ideas to score points. You never know—your chapter could be the next AAPC Chapter of the Year!

AMA Announces CPT® Code Changes for 2013

The American Medical Association (AMA) has released the CPT® code set for 2013. Expansion to the code set was necessary to accommodate "significant advancements in understanding and testing for the molecular basis of disease, including the Human Genome Project," the AMA said in a Sept. 17 press release.

There are more than 700 changes to codes that will go into effect Jan. 1, 2013, including 116 new molecular pathology codes. Additional CPT® 2013 changes reflect physician practice changes and technology improvements in cardiology, neurologic testing, and psychiatry.

Cardiology

There are 14 deleted and 47 new codes in the cardiology section. **David Dunn, MD, FACS, CCVTC, CIRCC, CPC-H, CCC, CCS, RCC**, vascular surgeon and vice president of ZHealth, Brentwood, Tenn., explained to *Coding Edge* what this signifies for coding these procedures. Coronary artery interventional coding has undergone a complete change in how these procedures will be reported with existing codes deleted and 13 new codes created. The new codes allow for much improved specificity for complex interventions. There are also specific codes for interventions when performed via bypass grafts, during acute myocardial infarctions, and in chronic total occlusions. Other new codes include:

- Eight for transcatheter aortic valve replacements
- Four involving ventricular assist devices
- Five for catheter ablation of arrhythmias

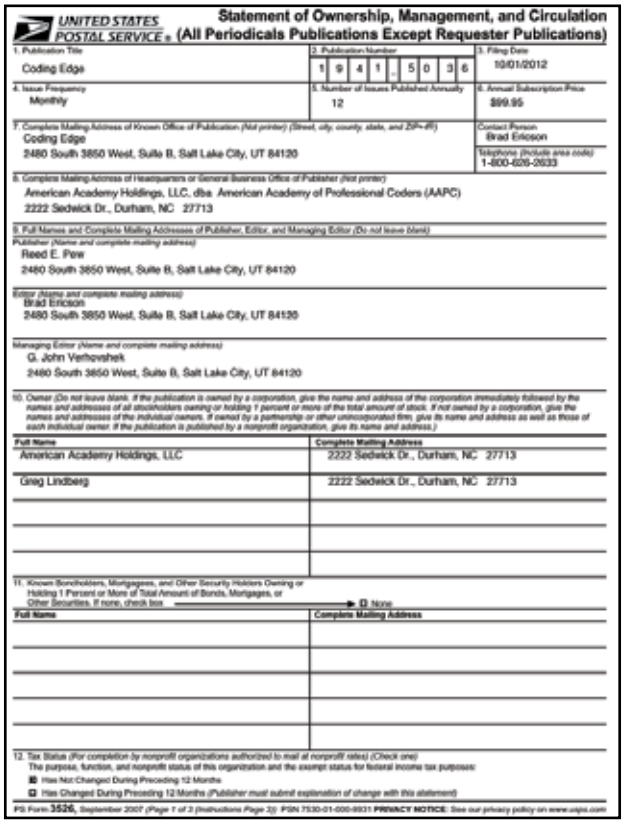
With these new codes are many new rules and bundling concepts you should know, as well.

Radiology and Endovascular

"There are 16 deleted and 18 new CPT® codes that will impact interventional radiology and endovascular procedures," said **David Zielske, MD, CPC-H, CIRCC, CCC, CCS, RCC**, an interventional radiologist and president of ZHealth and ZHealth Publishing. "The codes for diagnostic angiography of the head and neck have been completely revamped with deletion of all current S&I codes and creation of eight new unilateral codes that bundle catheter placements and imaging." There are new codes for thrombolysis procedures and retrieval of intravascular foreign bodies. Non-vascular code changes focus on thoracentesis and chest tube procedures.

Neurology

On the topic of neurology, **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, of MJH Consulting, said you "will need to perform one additional step in 2013 to compliantly report nerve conduction studies." After determining how many individual motor, motor with F-wave, sensory, and H-reflex studies have been performed, you "will need to add the total of all of the separate nerve conduction tests to determine which of the seven new CPT® codes



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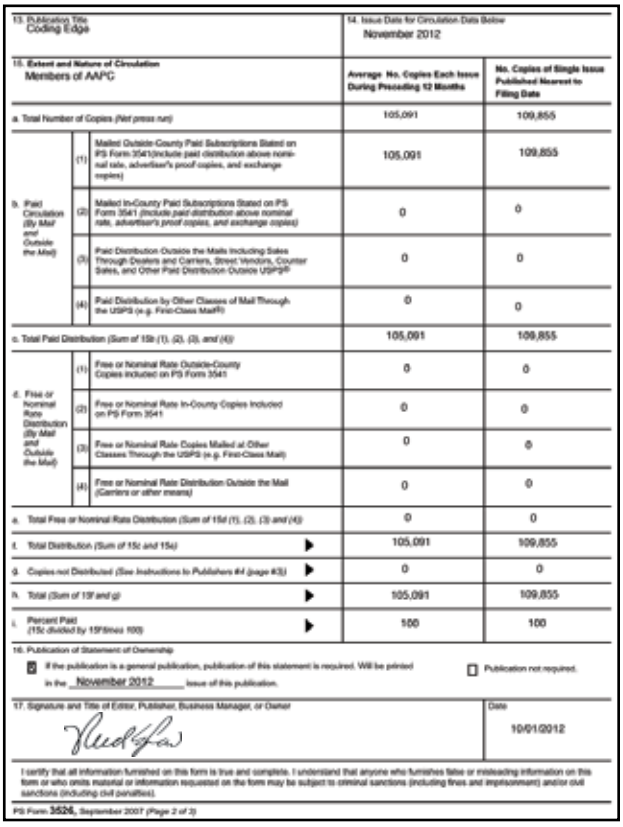

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PS Form 3526, September 2007 (Page 2 of 3)

would be reported," she said. You should understand "only one code would be reported with a maximum of 1 unit of service that represents all nerve conduction studies that were performed on that date of service," Hammer said.

Hammer warns to "watch how payers revise their coverage policies for the coding changes as well as the Maximum Number of Studies table found in Appendix J of the CPT® codebook. The majority of Medicare contractors as well as most commercial payers include a form of this table in their coverage policies that limits the total number of diagnostic studies allowed for a particular indication."

According to the AMA, new care coordination codes for 2013 will allow medical practices to efficiently report time spent connecting patients to community services, transitioning them from inpatient to other settings, and preventing readmissions.

More Information

- AAPC will hold half-day workshops Dec. 1-8 to prepare coders for 2013 code changes. Register for a workshop in a city near you at www.aapc.com/workshops/2013cpt.aspx.
- See the Sept. 17, AMA press release (www.ama-assn.org/ama/pub/news/news/2012-09-17-cpt-code-changes-2013.page).
- *Coding Edge* will provide more in-depth coverage of 2013 CPT® changes next month.

CPT® 2013 Errata Posted by AMA

CPT® 2013 codebooks were barely out of the warehouse when the AMA posted a corrections document. The document—available at www.ama-assn.org/resources/doc/cpt/cpt-corrections-errata.pdf—includes clarifying edits in guidelines and parenthetical comments, with two changes directly affecting coding.

OIG Releases 2013 Work Plan

The U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) has released the 2013 OIG Work Plan. By examining this plan, you can get an idea of what the federal government feels are areas of concern for physicians and hospitals. You can then take this information to create your own compliance (auditing and monitoring) work plan for 2013.

Coding Edge will cover the 2013 OIG Work Plan in detail in the coming months. Meanwhile, you can view the work plan at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/WP01-Mcare_A+B.pdf.

KUDOS

Please send your Kudos to: kudos@aapc.com

Sanford Luverne Honors Rita Von Holtum as Employee of the Year

Kudos to **Rita Von Holtum, CPC-H,** of Minnesota's Sanford Luverne for being honored with the "Sanford Health Eide Bailly Business Employee of the Year Award" on July 13.

The award came as a shock to Von Holtum, who said, "All week long we kept getting emails to come down to the dining room for a special announcement on Friday at 8:30 a.m., and that rolls and coffee would be furnished."

No one in Von Holtum's office had any idea what the special announcement could be. "Even as our CEO introduced my supervisor and explained the award, I was totally clueless," Von Holtum said. When her name was announced and her family walked in, "it was a very emotional moment!" Von Holtum said.

With 33 years of job experience, Von Holtum is the lead coder of the Health Information Management Department of Sanford Luverne, where she has been employed for 21 years. Sanford Luverne CEO Tammy Loosbrock said that Von Holtum "continually looks for ways to make sure our processes are flawless, sensible, and in compliance with payer, state, and federal regulations."

Von Holtum said, "I am truly humbled and honored that my peers nominated me for this award, and that I was selected."

Congratulations Rita for your achievement and for upholding a higher standard!

Rita Von Holtum, CPC-H

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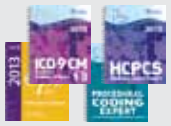	***Hospital Bundle 2*** ICD-9 1-3 • HCPCS • CPT® • Procedural Coding Expert	~~$418.80~~ **$219.95**

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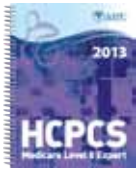

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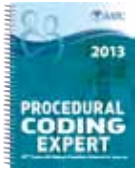

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By Jacqueline J. Stack, BSHA, CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC

Overcome ICD-10-CM Documentation Challenges

When providers understand what coders need, they can document accordingly.

No doubt you've heard that moving to ICD-10-CM will give you more specific choices for coding diagnoses. This data-driven code set will enable us to code to the highest level of specificity. But our ability to do that will still rely on how well physicians and other health care practitioners document their services.

This isn't a simple task because physicians do not typically document the way a codebook reads; they document for the care of the patient. Providers have their work cut out for them, too. Documenting for ICD-10-CM will be challenging because clinical documentation is used in many ways. Clinical documentation is also used for:

- Patient care
- Accurate and timely reimbursement
- Reporting statistical data to aide in quality reporting
- Assisting with financial planning and clinical data
- Protecting the physician, the patient, and the practice in a legal situation

As such, coders and physicians do not always "speak the same language." To break the communication barrier, and code with the increased clinical specificity ICD-10-CM provides, coders will need a comprehensive understanding of the types of disease and disease processes being documented.

Learn the Language

Example: A four-year-old girl falls off the monkey bars, causing an injury to her left arm. Based on X-rays, the physician determines the child has a buckle fracture of the left arm.

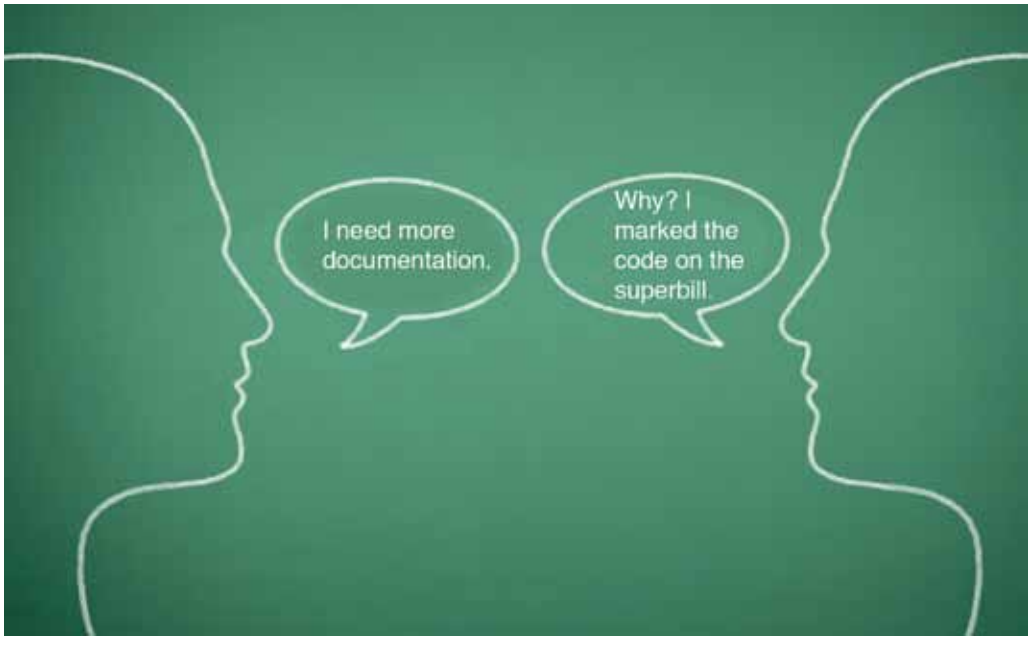
A buckle fracture (also known as a torus or incomplete fracture) is a common type of bone break in children where one side of a bone buckles upon itself without affecting the other side. With a good knowledge of fractures, the coder is able to choose a code that accurately describes the encounter based on the provider's documentation.

Educate Physicians

In addition to brushing up on your knowledge of anatomy and physiology (A&P), now is a good time to begin educating your providers on the new documentation requirements they will need to fulfill when ICD-10-CM is implemented on Oct. 1, 2014. Changing documentation neither requires providers to change the way they practice medicine, nor does it require extensive extra work. When the provider understands what the coder needs, he or she may be able to document the information by

Takeaways:

- Good documentation is key to successful ICD-10 implementation.
- Learn the language of documentation and teach it to your providers.
- Audit documentation to spot problems.



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When you meet with a physician, bring your code books, so he or she can see what the documentation challenges are.

adding just a few key words.

Laterality, for example, is expanded in ICD-10-CM; for many diagnoses there are code choices for right, left, bilateral, and unspecified. By adding one word to his or her documentation, the physician enables the coder to select the diagnosis with the highest level of specificity.

Example: A 70-year-old patient is seen for decreased hearing. After examination, the physician determines the cause was impacted cerumen.

H61.2 Impacted cerumen

- **H61.20** Impacted cerumen, unspecified ear
- **H61.21** Impacted cerumen, right ear
- **H61.22** Impacted cerumen, left ear
- **H61.23** Impacted cerumen, bilateral

Based on the documentation, the appropriate code in this case is H61.20. Had the provider added one word to specify laterality, however, you would've been able to code to a higher level of specificity.

Audit Documentation

To figure out where your provider's documentation is lacking, run a frequency report. Look at the top codes your providers use. You'll start here and work your way down the list.

Pull documentation for the most often used code. Compare that documentation to the corresponding ICD-10-CM codes. Does the current documentation allow you to select an ICD-10-CM code to the highest level of specificity? If so, move on to the next code; if not, make a point to explain to your provider(s) what sort of documentation would help you code to a higher level of specificity. When you meet with a physician, bring your code books, so he or she can see what the documentation challenges are.

If you do not feel comfortable with coding ICD-10-CM or determining where documentation needs to be changed, you can hire a consultant to do a review for you. Another option is AAPC Physician Services: They can provide low cost documentation assessments for providers. The service includes a preliminary assessment of 10 dates of service, a detailed report of findings, a half hour of webinar or telephone training based on their assessment results, and a follow-up assessment a few months later, of another 10 dates of service to measure results.

ICD-10 Documentation Requirement Examples

Consider the following common diagnoses as examples of documentation requirements you'll find when coding from ICD-10-CM.

› Diabetes Mellitus:

The codes for diabetes mellitus have been expanded in ICD-10-CM. To code for diabetes, the following information needs to be included in the documentation:

- Type of diabetes
- Body system affected
- Complication or manifestation
- If type 2 diabetes, long-term insulin use

Example: Mary is being seen today for follow-up of her diabetes mellitus. She was diagnosed three years ago with type 2 diabetes mellitus, which has been well controlled with insulin.

In this example, we know that the patient is a type 2 diabetic and that she uses insulin long term to control her disease. This example would be coded:

E11.9 Type 2 diabetes mellitus without complication

Z79.4 Long term (current) use of insulin

› Obstetrics:

Documentation must include:

- Trimester of pregnancy
- Week of gestation

Example: Mrs. Smith presents to her OB for her monthly checkup. She is 33 weeks, four days gestation. This is her first pregnancy, and she is doing well.

In this example, Mrs. Smith is in her third trimester, at 33 weeks gestation of her first pregnancy. This example would be coded:

Z34.03 Encounter for supervision of normal first pregnancy, third trimester

Z3A.33 33 weeks gestation of pregnancy

› Fractures:

The provider must document:

- Site
- Laterality
- Type
- Location

Example: A 30-year-old woman presents to the emergency department (ED) for an initial visit for treatment of displaced transverse fracture left tibia.

In this example the documentation tells us the site, laterality, and type of fracture. It also was the patient's initial visit, which is necessary information to code this to the highest level of specificity. This example would be coded:

S82.222A Displaced transverse fracture of shaft of left tibia, initial encounter for closed fracture

› Injuries:

When coding for the initial encounter of an injury, the provider must document the following to code to the highest level of specificity:

- External cause
- Place of occurrence
- Activity code
- External cause status

Example: A 30-year-old woman presents to the ED for an initial visit for treatment of displaced transverse fracture left tibia. The patient was on the balcony of her home. She was leaning against the railing, the railing broke, and the patient fell.

The documentation in this example shows us the external cause, as well as the place of occurrence. The documentation did not tell

us the activity or the external cause status. This example would be coded:

S82.222A

W13.0XXA Fall from, out of or through balcony, initial encounter

Y92.018 Other place in single-family (private) house as the place of occurrence of the external cause

› Asthma:

The provider should document:

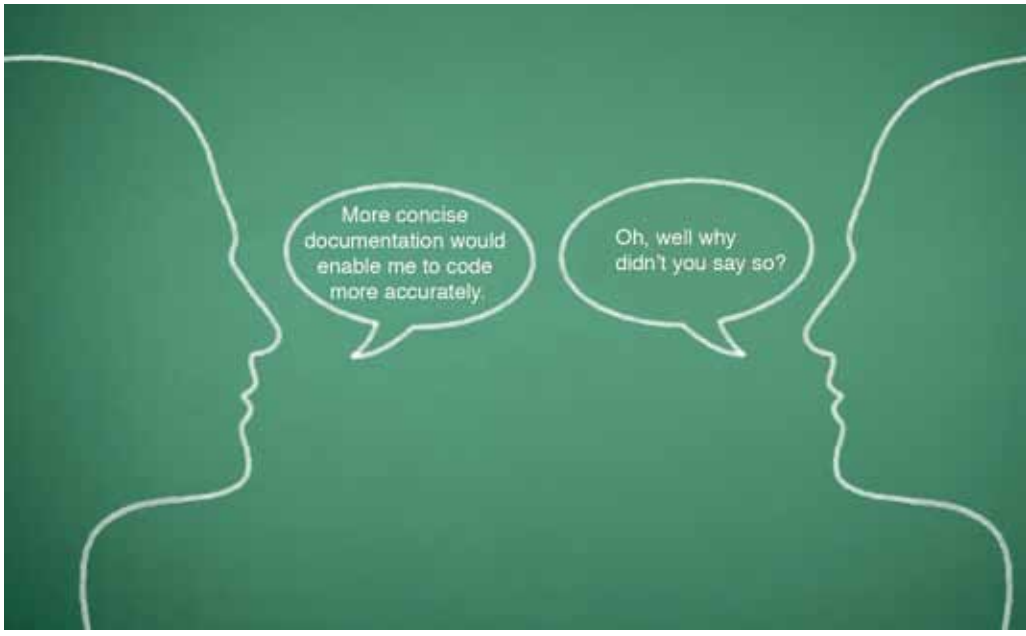
- Type
- Mild
- Mild intermittent
- Mild persistent
- Moderate persistent
- Severe
- With or without acute exacerbation
- With or without status asthmaticus

Example: A 7-year-old boy is seen by his physician for asthma follow up. The patient is doing well. He only occasionally has wheezing and coughing, and has used his rescue inhaler only a few times within the last six months. The physician diagnoses the patient with mild intermittent asthma.

This example would be coded:

J45.20 Mild intermittent asthma, uncomplicated

These examples show the documentation necessary to code ICD-10-CM to the highest level of specificity. Performing a documentation readiness assessment is essential for every practice. Work with your providers now to give them time to prepare for ICD-10-CM implementation and the new concepts they will need to understand.



Jackie Stack, BSHA, CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC, is ICD-10 specialist at AAPC.

A&P Quiz

By Jacqueline J. Stack, BSHA, CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC, CCP-P

Think You Know A&P? Let's See ...

Hashimoto's disease, also known as chronic lymphocytic thyroiditis, is a disorder that causes your immune system to attack your thyroid gland. This inflammation often leads to an underactive thyroid gland (hypothyroidism).

Hashimoto's disease is the most common cause of hypothyroidism in the United States, primarily affecting middle-aged women, but can occur in either sex at any age. It is treated with thyroid hormone replacement therapy, which usually is simple and effective.

Hashimoto's disease does not have unique signs and symptoms. Typically the disease progresses slowly over a number of years and causes chronic thyroid damage, leading to a drop in thyroid hormone levels in the blood. Signs and symptoms are mainly those of an underactive thyroid gland (hypothyroidism), such as fatigue and sluggishness; increased sensitivity to cold; constipation; pale, dry skin; a puffy face; hoarse voice; an elevated blood cholesterol level; unexplained weight gain; muscle aches, tenderness, and stiffness; pain and stiffness in your joints; muscle weakness; excessive or prolonged menstrual bleeding (menorrhagia); and depression.

Signs and symptoms gradually become more severe without treatment and the thyroid gland may become enlarged (goiter). Increased forgetfulness, slower thought processes, or increased depression also may be symptoms.

Test yourself to find out where your anatomy and physiology (A&P) skills rank:

The thyroid gland is part of which system?

A. Respiratory

B. Lymphatic

C. Digestive

D. Endocrine

The answer is on page 49.

Jackie Stack, BSHA, CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC, is ICD-10 specialist at AAPC.

To discuss this article or topic, go to www.aapc.com

By G.J. Verhovshek, MA, CPC

Modifier 57 Isn't Just for Surgery

Asking the right question can help determine whether to append it.

By appending modifier 57 *Decision for surgery* to an evaluation and management (E/M) code, you are telling the payer that the E/M service—on either the day of or the day before a major surgical procedure—was the service at which the physician determined surgery was appropriate and medically necessary, and that the E/M service should not be bundled to the surgery payment. If you miss the opportunity to appropriately append modifier 57, you miss out on deserved reimbursement.

Coding Edge regularly reviews best practices for applying modifier 57 (most recently in "Identify the Correct Global Period E/M Modifier," August 2012, pages 34-36), but an important point often overlooked is, despite its descriptor, modifier 57 also applies when the physician determines the need for any major *non-surgical* procedure.

When deciding if you should append modifier 57, the question you should ask is not, "Did the E/M service determine the need for a surgical procedure?" but rather, "Did the E/M service determine the need for a *major* procedure?"

90-day Global = Major Procedure

The CPT® codebook doesn't define "major" or "minor" procedures, but the Centers for Medicare & Medicaid Services (CMS) does, and many payers follow CMS' lead. CMS defines a major procedure as any procedure with a 90-day global period, as indicated in the Medicare Physician Fee Schedule Database (MPFSDB) or Relative Value File. CMS requires Medicare contractors, "pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT® modifier '-57' to indicate that the service resulted in the decision to perform the procedure" (*Medicare Claims Processing Manual*, chapter 12, section 30.6.6.c).

Bottom line: There is no Medicare requirement that a procedure must be "surgical" if modifier 57 is to be used, only that the procedure has been assigned a 90-day global period.

The Relative Value File, which can be downloaded from the CMS website, lists every HCPCS/CPT® code in alphanumeric order. To determine the global period for a code, locate the row containing that code and look to the column labeled "GLOB DAYS." Codes with a "090" indicator are major procedures. A small number of codes have a "YYY" indicator. Individual carriers determine the global period for these codes. Check with your payer for details.

Major Procedure = Modifier 57

If a surgeon sees a patient and determines she needs an emergency appendectomy, and the documentation spells this out clearly, you wouldn't question whether it is appropriate to append modifier 57. The E/M led to the decision for surgery, just as the modifier descriptor indicates, and both the E/M and the surgery may be reported, with separate payment for each. Easy, right?

What if an orthopedist sees a patient and determines (and documents) the need to provide non-surgical fracture care? Does modifier 57 apply? As you now know, whether the fracture care is a surgical service doesn't matter. What matters is if the fracture care is a major procedure (i.e., does it have a 90-day global period?). If yes, append modifier 57 to the E/M code. If no, you cannot. It's that easy!

For example, closed treatment of a clavicle fracture, either with (23505 *Closed treatment of clavicular fracture; with manipulation*) or without (23500 *Closed treatment of clavicular fracture; without manipulation*) manipulation may not be a "surgical" service, but it does have a 90-day global period, and it is a major procedure for which separate payment of an E/M service with modifier 57 is appropriate, when properly documented. In fact, the majority of fracture repair codes represent major procedures, with few exceptions (e.g., 24640 *Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation* has a 10-day global period).

Don't leave money on the table by failing to report a separate E/M service that determines the need for a major procedure. If you've been thinking of modifier 57 as the "decision for surgery" modifier, it's time to start thinking of it as the "decision for a major procedure" modifier. And, of course, for a separate E/M service that determines the need for a minor procedure (i.e., any procedure with a global period less than 90 days), you should turn to modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.*

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

If you've been thinking of modifier 57 as the "decision for surgery" modifier, it's time to start thinking of it as the "decision for a major procedure" modifier.

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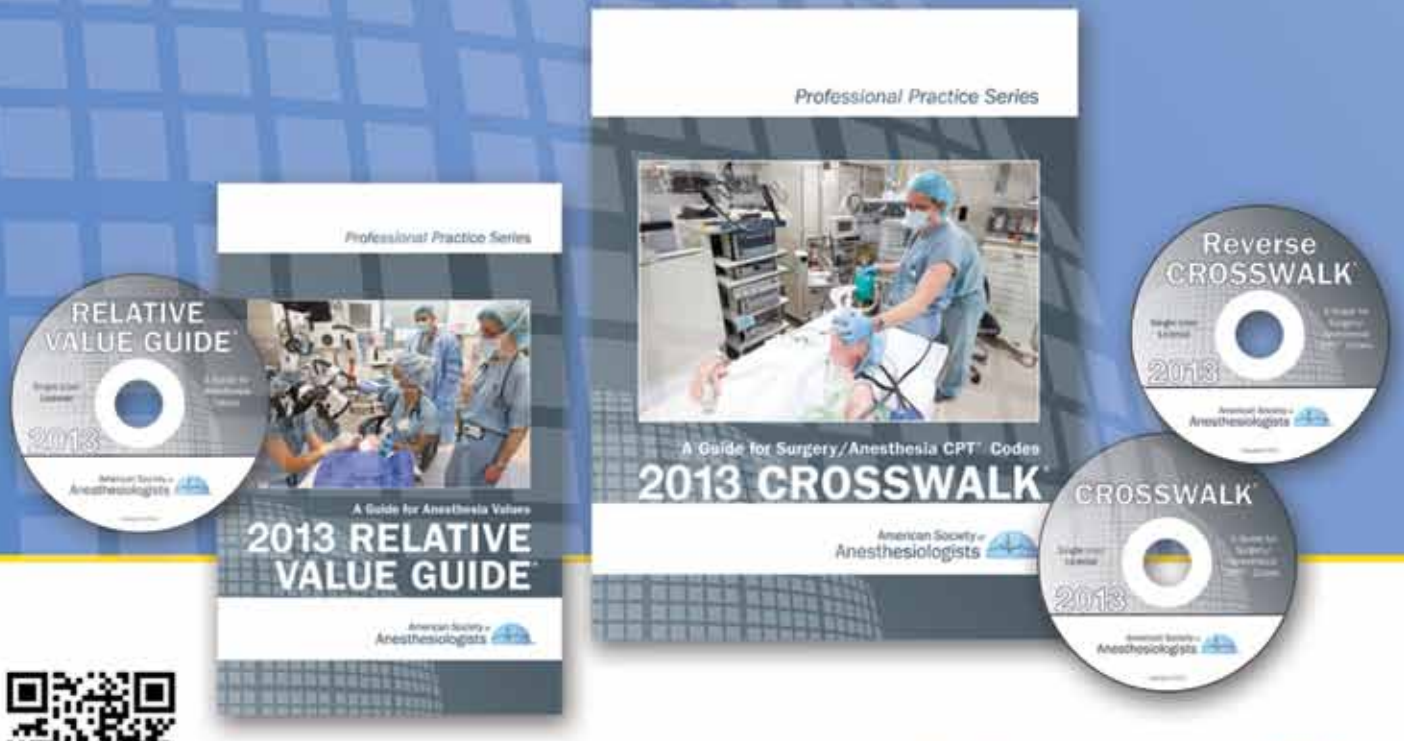

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American Society of Anesthesiologists

By Erin Andersen CPC, CHC

EHR Warning:
Under-documenting Is as Harmful as Over-documenting

Carefully questioning and reviewing the record can help you capture the correct level of service.

Takeaways:

- EHRs offer opportunity to bloat records with only part of what's needed for documenting E/M.
- MDM often goes under documented, and medical necessity is not completely justified.
- Use EHRs to your advantage, assuring the right amount of all needed information is included.

In the age of electronic health records (EHRs), patient encounter notes may become bloated with extensive histories, medication lists, and laboratory and radiology results that may not have been obtained during—and which are not pertinent to—the present visit. Ironically, physicians may have an overabundance of patient information, but fail to document some of the work they actually did, which can adversely affect the level of service reported.

In the outpatient/clinic setting, physicians perform a great deal of behind-the-scenes work to diagnose and treat patients. For instance, they review patient records, talk with other providers, order and review tests, and coordinate care. Most of these activities cannot be counted if the provider is billing based on time because they occur before or after the patient's visit. Physicians must describe this work in their notes, so the effort may be captured when the note is coded according to the elements of history, exam, and medical decision-making (MDM).

Determine if Your Physician Is Under-documenting

As a coder and a compliance specialist, I have reviewed tens of thousands of notes and have talked with hundreds of providers. Continually, certain items of MDM—diagnosis, data, and risk—go undocumented or unlabeled, and are unused when determining a level of service. Often, physicians are not upcoding as much as they are underdocumenting the services they perform. To help prevent this, I ask physicians a series of questions when I meet with them:

I see you have a number of patient complaints listed in your HPI, but not all of them are documented in your Assessment and Plan. Did you address any of these issues during the visit?
If the physician did address the complaints during the visit, they must be listed to substantiate that the physician was dealing with more than one health issue. This may increase the level of MDM—and possibly, the level of service.

Are you performing a record review?
Often, the record review summary is integrated within the HPI. When many specific dates, lab findings, and other detailed information are given in the HPI, ask the physician about the source of the data. If the record review is not separated from the HPI and labeled, the information may be attributed to HPI only, and he or she may not get credit in the MDM section for this work.

Do you review the patient's images or slides yourself?
If the physician performs this service and documents it, this may elevate the level of MDM.

Do you talk with the radiologist or pathologist?
Talking with the testing physicians can contribute to a higher level of MDM, when performed and documented.

Do you order additional records?
Sometimes patient records are not available for review before their visit. Obtaining additional information in a medical record can increase the MDM and, possibly, the level of service.

Continually, certain items of MDM—diagnosis, data, and risk—typically go undocumented or unlabeled, and are unused when determining a level of service.

Is your patient on a drug therapy requiring intensive monitoring for toxicity?

Many drugs require a patient to undergo frequent laboratory work to determine if the dose or the drug itself is causing adverse affects. "Intensive" is open to interpretation, but most payers would not consider testing for toxicity once or twice a year to be intensive.

Use Templates Wisely to Ease Documentation

Physicians may balk at having to document more than they already are. EHR templates can be set up with prompts or phrases that would be routinely used. We use the Epic system, and we have created phrases that the physician can select when appropriate.

These include:

- "This patient is on <drug name> requiring intensive monitoring for which I have ordered labs to check toxicity levels."
- "I have performed a record review. Pertinent details include: …"
- "I independently reviewed the patient's images. My findings are: …"

Does it make a difference in the level of service if the physicians document all of the work they do? Yes! Maybe not for every visit, but for some it could make a big difference.

EHR Scenario Reveals

Let's take a look at a hematology/oncology example:

A new patient comes in to discuss treatment options for a newly diagnosed cancer, for which the patient has few symptoms and is doing well. The physician documents a comprehensive history and exam, orders labs, pulls in other lab work and radiology from the EHR system, and discusses the need for chemotherapy. The documentation shows:

Diagnosis: New problem needing work up (4 points – high complexity)

Data: Lab and radiology review (2 points – low complexity)

Risk: Prescription drug management (moderate complexity), new problem with uncertain prognosis (moderate complexity)

Based on the above documentation, the visit would equate to a 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity.*

But I suspect this documentation doesn't tell the whole story. Let's say we meet with this physician and ask all of the aforementioned questions. The physician tells us that he did a record review and looked at the patient's images himself. With this new information and improved documentation, we can reconsider the level of service:

Diagnosis: New problem needing work up (4 points – high complexity)

Data: Record review (2 points), independent review of images (2 points), orders additional lab work (1 point): Total of 5 points = high complexity

Risk: Prescription drug management (moderate complexity), new problem with uncertain prognosis (moderate complexity)

Based on the additional data the physician reviewed, the improved documentation changes the level of service to 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity.* The original documentation showed a low complexity for data; whereas, the improved documentation shows high complexity. What's the difference? About $40 for each visit of this nature.

Erin Andersen, CPC, CHC, has worked in coding and compliance since 2003 at Oregon Health & Science University performing chart audits and educating providers, coders, and staff about coding and billing. She is the education officer in the Rose City AAPC Local Chapter in Portland, Ore., and one of the Region 8 representatives on the AAPCCA Board of Directors.

By G.J. Verhovshek, MA, CPC

Three Solutions for Suture Removal

In most circumstances, you would not code separately for suture removal. There isn't a dedicated CPT® code for suture removal, and both the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) consider suture removal to be an integral part of any procedure that includes suture placement.

For example, if a physician performs layered closure of a 3.5-cm laceration on a patient's face, and nine days later removes the sutures, the removal is included in the 10-day global package of the repair code (12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6-5.0 cm*).

Exceptions to the Rule

In some cases, however, you may be able to report suture removal separately. For example:

1. A different physician removes the sutures than who placed the sutures.

When this occurs, you have the option of reporting the same code that described the initial procedure and appending modifier 55 *Postoperative management only*. Postoperative care usually accounts for approximately 10 percent of the procedure's value.

Returning to our example above, suppose an emergency department (ED) physician performed the wound repair (12052), but the patient's primary care physician (PCP) removed the sutures at a later date. In an ideal world, the PCP would report 12052-55 for postoperative care (including suture removal).

Because the world is far from ideal, however, several problems may arise in this scenario. Not only would the physician providing postoperative care need to know exactly which CPT® code was reported by the physician who provided surgical care, but the physician providing surgical care also would have needed the foresight to report his services with modifier 54 *Surgical care only* appended to the procedure code. In other words, the physician providing surgical care and the physician providing postoperative care would have to coordinate their billing because the payer will not pay twice for the postoperative portion of the service.

An alternative tactic is to report a low-level evaluation and management (E/M) service for a problem-focused visit, especially when suture removal occurs outside of the global period. As always, documentation must support medical necessity for the visit.

2. Sutures are removed under anesthesia.

This circumstance is rare, but when documented and supported by medical necessity, you may report 15850 *Removal of sutures under anesthesia (other than local), same surgeon* or 15851 *Removal of sutures under anesthesia (other than local), other surgeon*, depending on whether the same surgeon who performed the initial procedure, or a different surgeon, removed the sutures.

3. Your payer accepts S codes.

Some private payers (but not Medicare) may accept S0630 *Removal of sutures by a physician other than the physician who originally closed the wound* for suture removal, as long as the physician who removes the sutures isn't the physician who placed them.

In any case, when suture removal is the primary reason for the patient encounter, report V58.3 *Encounter for other and unspecified procedures and aftercare; attention to surgical dressings and sutures* as the first-listed diagnosis.

photo by iStockphoto/Owvik58

Alternatively, a physician might report a low-level evaluation and management (E/M) service for a problem-focused visit, especially when suture removal occurs outside of the global period.

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

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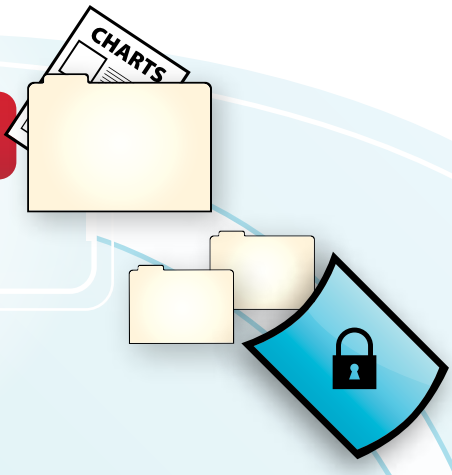

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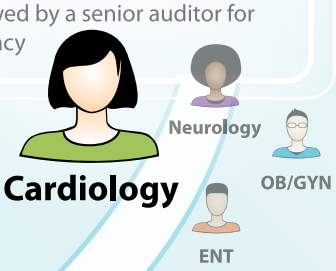

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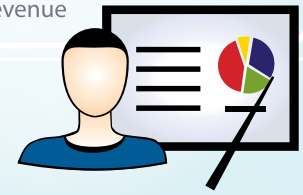

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By Angela Jordan, CPC

Coders Are Essential in EHR Implementation and Use

Employing someone who knows documentation, coding, and billing rules will keep things running smoothly.

The key to successful electronic health record (EHR) implementation is not only selecting the right system, but ensuring you have the right people involved in the process from day one. The team should be comprised of one member from each area of the practice to represent all who ultimately must use the system.

Which means: Don't forget the coder.

Coding Experience Proves Valuable

In 2008, after only one year in my new position as coding and compliance manager, I was chosen to be part of a team to oversee the practice's transition to EHRs. To fulfill my role, I attended three EHR demonstrations back to back (to back). Each sales team was set up in a conference room on a different floor of the building. It was speed dating with software vendors.

Each vendor assured the providers they could reduce or eliminate coding staff because the EHR would allow them to document and code more accurately. While watching the first demo, however, I realized that I would be able to ask questions that office managers, nurses, and physicians weren't even aware to ask, such as:

- How are the evaluation and management (E/M) levels calculated?
- Can you disable the "All Systems Reviewed" button?
- Does the provider have the option to use the 1995 or 1997 physical exam?
- Can you make medical decision-making (MDM) one of the required elements?
- Does it keep track and authenticate who is entering the information for each visit?
- How timely is the system updated for ICD-9-CM and CPT® codes each year?

As I listened to the software vendor's responses, I noticed the expressions on the faces of a few of the managers and physicians. It was a mixture of "Why is that important?" and "I wish we would have asked that when we selected our *first* EHR."

I left the demonstration that day feeling confident about the contributions a certified coder could make during the selection and implementation of an EHR, especially one well versed in E/M, documentation guidelines, and auditing. Coders who embrace this technology and learn as much as they can about it are, and always will be, invaluable to the practice of medicine.

When It Comes to Training, One Size Does NOT Fit All

When an EHR vendor was chosen, "super users" like me were trained on how to troubleshoot the system. Anyone who has gone through the implementation of a practice management system or EHR knows vendors rarely provide enough training. Most trainers come from a front office background or are clinicians themselves. They have health care knowledge, but aren't accustomed to documentation, coding, and billing rules. They teach you how to use their product. And in our case, although our trainers really knew the system, they trained us to use it only one way. The problem is: One size does not fit all.

As the first offices went live with the chart portion of the EHR, I shadowed our trainers (who had been trained by the vendor). I interjected correct documentation and coding practices whenever a trainer taught the providers improper coding or documentation. As the providers started to use the system on their own, I performed random reviews.

When our last and largest office was ready to go live, I trained several of the providers. It was a great opportunity because I applied what I had learned from the previous deployments done by the vendor trainers. I worked with the key staff to break down the workflows and develop step-by-step guidelines to handle every process, from taking phone messages to transferring key patient information from the paper chart into the EHR. The whole point was to make it easier for the providers receiving their training next.

Takeaways:

- EHR implementation is successful if the right people — especially coders — are involved.
- Speak up to assure coding needs are met when selecting and training on a new EHR system.
- Work with your providers to assure they are documenting adequately and coding correctly.

From day one of provider training, I focused on all of the issues in paper charts. I explained history of present illness (HPI), review of systems (ROS), past medical, family and social history (PFSH), and exactly how the EHR calculated them. As the providers built their templates, they finally understood 1997 E/M guidelines for a bulleted exam. The diagnosis "favorites" list and look-up function was a challenge, but after providers began to use it, they understood why accurate coding is reliant on comprehensive documentation.

While working on the plan and patient instructions of provider templates, we discussed medical necessity and how MDM is typically calculated. That was another "Aha!" moment for some of the providers. As we discussed how they cared for their patients, they understood why it was important to summarize outside records they had reviewed and to document additional information obtained from other sources.

Most trainers ... have health care knowledge, but aren't accustomed to documentation, coding, and billing rules. They are there to teach you how to use their product.

Help Out During the Process

After two days of one-on-one training, it was time for the providers to start seeing patients and apply what they had learned. I shadowed them for five days. During that time, I answered their questions, fixed templates by adding things they didn't know were necessary, helped them customize their user settings to work more efficiently, and simply provided positive moral support. They knew I was there to support them and help them—not only to document accurately, but also to be in compliance with federal rules and payer policies. They knew that if they had a question in the future, there was someone they could call who knows the software, is well versed in coding and documentation guidelines, and could understand and answer their questions in a timely manner.

A year later, some of the providers are already back in full production. There are a few who still "click count," and want the vendor to rewrite parts of the software. Some providers contact me regularly, wanting to know how a template change will affect coding. There are even a few who are ready to tackle quality measures without putting up a fight. The best outcome is that the providers have a better understanding of E/M, which ultimately has improved their documentation.

CPCs® Can Prove Their Worth

Upon completing the transition, I knew I had been successful in proving the value of a Certified Professional Coder (CPC®) as an EHR implementation team member. When I returned to my office, I was pleased to find among the stack of mail on my desk a card with a personal note from each physician and nurse practitioner I helped to train, thanking me for my time, patience, and understanding. To this day, that card is on my desk to remind me that EHRs will never replace coders.

Angela Jordan, CPC, is the manager of coding and compliance for EvolveMD in Lenexa, Kan. She is the trainer for Greenway PrimeSUITE, providing provider and staff education, coding and documentation reviews, and review of carrier coding/reimbursement policies. Angela is also AAPCCA Board of Directors chair, representing Region 5 – Southwest, and the Kansas City chapter president.

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By Jaci Johnson CPC, CPMA, CEMC, CPC-H, CPC-I

Advanced E/M Compliance: Beyond Level-of-service Coding

Determine if the documentation supports coding *and* the scrutiny of a compliance audit.

Takeaways:

- E/M coding documentation must stand up to compliance scrutiny.
- Choose reliable resources for your information.
- Focus on complete records to assure all supportive documentation is included.

Whether performing an audit or providing education, when it comes to evaluation and management (E/M) coding, your first consideration should be accurate, compliant information and results.

Choose Reliable Resources

Our reliable resources are the Centers for Medicare & Medicaid Services (CMS) *1995* and *1997 Documentation Guidelines for Evaluation and Management Services*, the Office of Inspector General (OIG) website for compliance guidance, and the CPT® and ICD-9-CM codebooks for specific coding rules. Medicare administrative contractors (MACs) are also good resources for finding information unique to each geographic area.

Why are these recourses so important? If you choose to educate or audit without these stated rules, you'll impart your opinions in a very crucial area where there is no place for opinions.

Compliance Supersedes Coding

Audits and education for E/M services should go beyond determining the level of service. Many compliance issues can cause the documentation of an E/M service to fail an auditor's review. The resources noted above will outline key areas where provider documentation will be at risk for noncompliance, even when the level of service is supported by the documentation. When reviewing E/M documentation, remember the items that make the documentation "complete," as defined by CMS and the OIG.

Focus on Complete Records

Let's take a look at the areas that continually threaten the completeness of the medical record:

Relevant History: Each record must state the reason for the encounter, any relevant history, and the exam. The chief complaint must be clearly indicated and the relevant history of the condition(s) that warranted the visit must be documented. In other words, the documented history should have some relationship to the reason why the patient is being seen. Too often the history bears no relevancy on the date of service, and instead reads like a past medical history of many problems not addressed at that visit.

Documentation of the History: The only part of the history that may be documented by a nurse, student, ancillary staff, or the patient is the review of systems (ROS) and/or past, family, and social histories (PFSH). The provider (doctor of medicine (MD), doctor of osteopathy (DO), nurse practitioner (NP), physician assistant (PA), etc.) must document the chief complaint and history of the present illness (HPI).

If someone else documents the ROS or PFSH, there must be a notation supplementing or confirming that the provider reviewed the information. If that confirmation is not a part of the record—even if the patient information supports the level of service—the documentation does not meet the compliance rules, and does not count.

Orders for Diagnostic Tests: If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. This seems simple enough, and yet it can cause many problems. Compliance issues normally arise in paper records more than in electronic records, where orders for diagnostic tests are often linked to a particular diagnosis.

From a compliance standpoint, an auditor must be able to determine that the *provider* made the decision to order a diagnostic test. Documentation that supports the order provides data when determining the level of medical decision-making. Without documentation showing the provider ordered the test—and even if the test results are docu-

Too often the history bears no relevancy on that date of service, and instead reads like a past medical history of many problems not addressed at that visit.

mented—an auditor may infer that ancillary staff ordered the test.

Signatures: Per CMS, a signature is "a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation." This statement does not indicate the signature must be a complete name. In the event of an audit, a provider may provide a signature log to reflect the signature with a typed name. In the instance where a medical record is submitted without a signature, an attestation can be submitted as proof that the provider saw the Medicare beneficiary on that date of service.

Signatures are crucial to validate who saw and participated in the care of the patient. Regardless of the caregiver (e.g., nurse, medical assistant (MA), certified medical assistant (CMA), NP, MD), there must be a signature showing this health professional documented an encounter in the patient's medical record. Auditors look carefully at who is signing notes and how the notes are signed, which can provide insight into noncompliant practices. Signatures (or the lack of signatures) can reflect who is performing services, versus who is *supposed* to be performing services.

A good resource for additional signature guidance is your MAC.

Participation of Medical Students: This often comes up in an E/M audit, and goes back to who is allowed to document and perform certain parts of the patient encounter. A medical student may document only the ROS or PFSH, and the provider must confirm that information. Because this is a teaching situation and the student may be asked to take a history and/or perform an exam, as well as document his or her findings, it's important to understand how that documentation can be used, if at all. The teaching physician must re-perform and re-document his or her own history and exam. Only the work and documentation of the teaching physician will be used for determining the level of service.

Make Sure Guidelines Are Met

When auditing or educating for E/M services, it is crucial to look beyond the level of service to determe if guidelines have been met. Much goes into determining if the medical record is complete. Read the tools and resources and consider each encounter note carefully to determine if the documentation can withstand both coding and compliance audits. CE

Jaci Johnson, CPC, CPC-H, CEMC, CPMA, CPC-I, is president of Practice Integrity, LLC. She has worked in medical coding and auditing for 24 years and has been a Certified Professional Coder (CPC®) since 1994. Ms. Johnson has expertise in coding for family practice, urgent care, OB/GYN, general surgery, and Medicare's Teaching Physician Guidelines, with a particular emphasis on E/M guideline compliance. She serves on the AAPC National Advisory Board (NAB), and is past president of her AAPC local chapter. She was also recognized as Virginia's 2006 Coder of the Year.

By Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CPC-I, CHCC, CENTC

Ask the Right Questions Before Outsourcing Your Billing

Choose wisely to stay compliant and eliminate financial frustration.

Many practices enjoy the benefits of outsourcing their billing functions, such as the ability to concentrate on providing patient care. Choose the wrong billing company, however, and you may end up with even greater distractions and financial frustration.

Meet Your Billing Needs

To be sure you choose a billing company that meets your needs efficiently—and does so compliantly—do some homework to answer the questions below:

Q. What credentials/experience does the billing service have?

Find out how long the billing company has been in business and what sort of reputation they have. You'll also want to know if they are registered or licensed by the state they are in (if their state requires it), and if they carry professional liability insurance. Ask if they provide a written contract for their services spelling out each party's responsibilities in the business relationship. And don't be afraid to ask how many clients they have, and if they have any clients similar in size and patient mix to your practice. Get references, too, so you can contact current and previous clients and ask for their opinions of the service's performance.

Q. Does the billing company have experience in your specialty?

The billing company should understand the unique factors affecting your specialty; and they should have an appreciation for the issues surrounding your coding, reimbursement, denials, and appeals. If not, ask if they have the resources to get up to speed, to your satisfaction, so your revenue does not suffer.

Q. What kind of training does the staff have and receive?

Find out if the billing service's management hold certification from a professional billing organization, and if there are billers and professionally certified coders on staff. If so, dig deeper to find out if the service provides ongoing education and guidance for these employees.

You have a right to know this information, as well as what resources the biller provides for its staff. Code books (CPT®, HCPCS Level II, etc.) should be up-to-date. The service also should have a written compliance plan. If it does (and you need to be sure), ask if you can you review the plan. Speaking of compliance …

Q. What is the procedure to protect the privacy of information?

Inquire into whether the service has a compliance officer, or someone who ensures the billing company provides secure (encrypted) email communications consistent with

Even if the billing company is not coding for you, it's a good idea for them to have at least one certified coder on staff.

Health Insurance Portability and Accountability Act (HIPAA) requirements. You also should be aware of whether the billing company uses home-based employees and, if so, what precautions are taken to ensure HIPAA compliance.

What are the company's technical capabilities?

Do they electronically process and submit claims, either directly to Medicare or through a clearinghouse? Ask how often claims are submitted to the clearinghouse; what the process is for third-party payers; and if they use batch controls to minimize data entry and other errors. Make sure you know if the service will help your practice with forms, superbill design, office processes, etc.

How does the biller handle claim changes?

Learn what the service's protocol is for changing CPT® or ICD-9-CM codes if errors are discovered. What's the protocol for missing information?

What type of financial reporting does the billing company provide?

For instance, can the practice request ad-hoc reports? Ask whether the service can provide reports to determine physician compensation levels. If the practice is capitated, can the billing service report on capitated service utilization? Also inquire into whether your practice can access billing data at its office; and ask to see samples of their month-end reports to find out how robust they are.

How is the billing company's follow-up practices?

Specifically, how successful are they with appeals? Ask what parameters they use to determine if they will appeal a denial or underpayment. Find out the kind of accounts receivable (A/R) follow-up procedures they have. And ask how often the service follows up on payer accounts.

How much will everything cost?

If the billing company's fee is based on a percentage, find out if it is a percentage of charges, or a percentage of receipts (the latter is better). Also find out how refunds are handled. Are they netted out of receipts, so your practice is not paying the billing company for money returned to the payer? And don't forget to ask if the billing service charges a start-up fee.

If the answers to any of these are not to your satisfaction, keep looking until you find a billing service that meets your expectations.

Remember: Even though you are outsourcing, the practice is ultimately responsible for its own claims. You need a billing company you can trust.

Experienced Staff Is Crucial

Even if the billing company is not coding for you, it's a good idea for them to have at least one certified coder on staff. Appeals require the knowledge of a coder, and compliance also demands the increased knowledge that a certified coder can bring to the table. Even the billers need to know aspects of coding to do an excellent job in billing for your practice. Key areas of education include rules and regulations, where to find the information for Medicare, Medicaid, your private payers, modifiers, correct order of diagnoses, bundling and National Correct Coding Initiative (NCCI) edits, what separate procedures are, etc. You do not want a billing company that is just providing data entry.

Best Bets

Find a billing company with experience in your specialty, with a proven track record in compliantly optimizing practice revenue. I would not recommend entering into a billing company relationship without a written contract that very explicitly spells out each party's responsibility.

Compliance is no longer an option. The Patient Protection and Affordable Care Act (ACA) mandates a compliance plan for all practices, with minimum requirements to be spelled out by the Office of Inspector General (OIG). A practice cannot afford to contract with a billing company that does not have a living, breathing, and operating compliance plan in place.

Check out the billing company's recommendations. Talk to both current and past clients, if possible. Find out what the benefits of working with the billing company are, and what's required of you to make the relationship function flawlessly. Clients should be able to confirm what the company has told you during the sales phase of your relationship.

Finally, do not expect to see your full income generated by the billing company for approximately four months. It takes about that long for them to get a full queue of your billing into the payers and a revenue stream to start flowing into the practice. Make sure you keep collecting on the A/R that was in process when you contracted with the billing company to keep the bank account healthy during this initial period.

Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC, is president of CRN Healthcare Solutions and senior coder and auditor for The Coding Network. She is consulting editor for *Otolaryngology Coding Alert* and has spoken, taught, and consulted widely on coding, reimbursement, compliance, and health care-related topics nationally.

By Stephen C. Spain, MD, FAAFP, CPC
Angela "Annie" Boynton, BS, CPC, CPC-H, CPC-P, CPC-I, RHIT, CCS, CCS-P, CPhT

Editor's note: Health care reform brings a number of new concepts to coding, billing, compliance, and practice management. The most far reaching—especially from an organizational point of view—are accountable care organizations (ACOs). Below is the first of three articles detailing why ACOs exist, how they work, and what affect they will have on us.

Health Care Quality and Value: Foundation of Health Care Reform

Part 1: Initiatives steer towards reducing waste and increasing efficiency.

"Quality" and "value" have percolated to the top of health care payers' concerns in recent years. Payer initiatives currently in development will have a substantial, pervasive, and dramatic impacts on virtually all AAPC members—and on patients and providers, as well. These initiatives focus on reducing unnecessary medical services to lower costs, and on identifying effective practice patterns.

Takeaways:

- Most payers, including CMS, are looking at EBM as a way to only pay for medically necessary care.
- Patients and providers must find middle ground between expectations and best practices.
- Quality measures facilitate finding a middle ground between quality care and valuable care.

The Challenge Ahead

The United States has the planet's highest per capita health care expenditures. In 2010, we spent $2.6 trillion on health care (an amount equal to the entire economy of France). By 2019, an estimated 19 cents of every dollar will be spent on health care. Even as health care costs rise rapidly, significant federal regulations require additional expenditure and investment in health care infrastructure and technology (e.g., 5010, ICD-10-CM, administrative simplification, health care reform, health information exchanges (HIEs), etc). Many industry stakeholders and lawmakers are looking to payers and providers for ways to reduce costs, while ensuring efficacy and quality.

Nearly 32 million Americans do not have health insurance, which places an additional burden on health care reimbursement (the number of uninsured may change due to provisions in the Patient Protection and Affordable Care Act (ACA)). Patients without health insurance often do not seek care until they are very sick, which requires higher levels of care and higher utilization (e.g., emergency room (ER) visits, high-end radiological studies, etc.). For many uninsured, the ER—perhaps the most expensive setting in which to receive care—is the sole means of care. This requires states and hospitals to create uncompensated care pools for economically qualifying individuals. Uncompensated care pools lift health care costs through write-offs, increases in delivery costs, and higher premium rates.

For Payers, Quality Requires Value

As patients, when we consider the quality of our health care, we may think about how well trained our providers are, or how well equipped our local hospital is. But for those paying for health care on our behalf (employer-engaged insurance companies and the Centers for Medicare & Medicaid Services (CMS)), quality is defined as value received for the dollars spent. Payers don't want to waste money on care that is medically unnecessary, care that is billed but not rendered, or treatments that are not proven.

In response, many payers have taken steps to implement quality-monitoring measures outside of the traditional-managed care model. For example, payers may create wellness programs and disease management programs to promote effective treat-

Payers don't want to waste money on care that is medically unnecessary, care that is billed but not rendered, or treatments that are not proven.

ment methods and drive higher quality of care. Typically, payers will target high cost (often chronic) conditions such as diabetes, asthma, kidney disease, and heart failure, and create resources and tools to ensure that patients/members understand what quality care is and that participating providers are rendering the best care available. We know from quality measures that disease management is helping performance outcomes around many chronic conditions; however, health care costs continue to rise. Although helpful from a quality perspective, disease management is not enough to curb rising costs.

A New Response to Better Care and Contained Costs

Many payers (including CMS) are looking to evidence-based medicine (EBM), a widely applied principle of identifying treatments and practice habits that are proven to be beneficial, and are encouraging all practitioners to adopt these treatments and practice habits as a universal "gold standard" or "best practices."

Before EBM, as new advances were made in medicine, it was assumed that the information would trickle down in meetings, seminars, and publications and that eventually all practitioners would become aware of the advances and adopt them. In reality, this model did not work. Providers trained one way generally stuck to what they knew, and were not eager to adopt new ways of practicing medicine.

In the 1990's, the U.S. Preventive Health Services Task Force (USPSTF) was organized to review available medical data and make recommendations on which preventive services (Pap screening schedules, mammography screening, colonoscopies, etc.) should be applied to the entire population. Several medical groups, such as the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP), decided to build on the work of the task force and identify meaningful diagnostic and medical treatments for a variety of conditions. Where double-blinded, controlled studies support a recommendation, it would have the highest rating. Where medical study or evidence supporting a treatment or service is lacking, the item would have the lowest recommendation (or would not be recommended at all).

For example, at one time patients complaining of low energy were commonly given 1,000 units of B-12 as an injection. Studies eventually showed that there was no appreciable benefit to B-12 injections; therefore, B-12 injections for a "boost" are *not* recommended. (CMS stopped paying for B-12 injections with a fatigue diagnosis many years ago.)

Finding the Middle Ground

Patient expectations can lead to difficulties in implementing EBM recommendations. For example: Studies have shown that X-rays for an acute ankle sprain, in the absence of other risk factors, are not necessary. Several medical groups are on record as advising against X-rays in the initial evaluation of an acute ankle sprain. Following EBM guidelines, providers would not routinely order X-rays for the average patient with an acute ankle sprain.

But what happens when you go to the ER with an ankle sprain? Almost always, your ankle will be X-rayed (and almost always, the X-ray will be normal). The patient wants reassurance, and the ER doctor does not want to risk being sued on the remote chance that he might miss a fracture. Patient pressure and medical liability worries result in an unnecessary X-ray. Hundreds of thousands of such unnecessary treatments are rendered every year.

EBM will likely ensure medical care improves in both quality and value. But based on our example, EBM might not provide the care the patient wants or the physician is comfortable providing. The goal is to find the point of equilibrium, where our health care delivery system offers quality and value, as well as improved outcomes. It will take time, patient and provider education, and control of liability exposure to incorporate EBM into everyday medical care.

How Quality Measures Enhance Value

Payers (CMS in particular) have turned to the reporting of "quality measures," most of which are based on a framework provided by EBM, to improve the value received for health care expenditures. Just after the turn of this century, CMS created the Premier Hospital Quality Improvement Project. It offered incentive payments to health professionals for reporting quality measures. You may have heard of this as "pay for performance" or "P4P." The idea was to test the hypothesis that providers would report quality measures if they were paid extra to do so. It was a very successful experiment and proved that paying extra could produce the information CMS was seeking. From this experiment, the Physician Quality Re-

Patient pressure and medical liability worries result in an unnecessary X-ray. Hundreds of thousands of such unnecessary treatments are rendered every year.

porting Initiative (PQRI) was born. PQRI has since become a permanent program, renamed the Physician Quality Reporting System (PQRS).

PQRS relies on "measures" tabulated over the course of a patient's treatment. CMS realized it needed help from the medical community to determine what measures were important. EBM was used, wherever possible, as the guiding principle. The actual quality measures were developed by various medical organizations, such as the AMA, the American Gastroenterology Association (AGA), and others. These groups have put together several hundred measures that cover issues pertinent to most medical specialties and health care providers.

As an example of how a quality measure enhances value, consider the pneumonia vaccine. There is a quality measure for reporting that a patient is current on a pneumococcal pneumonia vaccine. If the patient is noted to be current at a visit, a code is added to the patient's claim. If a provider finds that a patient is not current on his or her vaccine, he would administer the vaccine and report the code for that service, as well as a quality measure code for providing the vaccination. In this way, fewer patients will slip through the cracks and fewer Medicare patients will succumb to pneumococcal pneumonia. The value comes from the saved expenses of pneumonia treatment and hospitalization.

Quality Measure Reporting Requirements

Early indications are encouraging that reporting of quality measures will make providers less likely to overlook vaccinations (pneumonia, flu, tetanus, hepatitis B), preventive screenings (colonoscopy, Pap smear, mammography, PSA screening), counseling on health issues (smoking, obesity, fall risk), and treatments known to be effective for certain health conditions (statins for diabetes and heart disease, ACE inhibitors for congestive heart failure, aspirin for early myocardial infarction, anticoagulants for atrial fibrillation). A provider can pick several pertinent measures and report those for a year for the applicable patient encounters. The measures can be reported by either attaching a HCPCS Level II code to the claim for the encounter, submitting the information to a third-party registry, or through an electronic health record with PQRS reporting capability built in.

As an example, an endocrinologist may decide to report measures for diabetes. There are a number to choose from, but here are three that could be used:

- DM: Hgb A1C with poor control A1C >9.0%
- DM: LDL cholesterol controlled LDL-C < 100 mg/dl
- DM: High BP controlled BP < 140/90

Three measures are selected because three is the minimum number of quality measures a provider can report to be eligible for a bonus payment. To successfully report these parameters, the provider must address and report these items once in the course of the year—ideally, for every patient seen with a diabetes diagnosis. To qualify for an incentive payment, the measures must be reported for at least 80 percent of the eligible encounters.

There is no way to track progress with CMS over the course of the year, and many providers only learn after the year has ended if they met the criteria for a bonus payment. Currently, the bonus is 0.5 percent of the total Medicare payments received by the provider for the year. Unless there are changes, the bonus is phased out after 2014. Starting in 2015, penalties will apply for providers who do not report or who improperly report quality measures. The penalty in 2015 is 1.5 percent, which will increase to 2 percent in 2016, and will be applied against *ALL* Medicare payments.

CMS is not doing much with the quality measures data it is collecting, but that will change. Right now, most of the measures seem to be aimed at making sure that important treatment guidelines are not overlooked (e.g., blood pressure goals and aspirin for heart attack victims, and certain drugs for heart failure and diabetes care).

Measures' reporting is almost certainly here to stay. Note that PQRS preceded and is separate from the ACA law, so PQRS is not likely to be affected by changes in the ACA interpretation or implementation.

Next month, we will feature part two of this three-part series: The (R)evolution of the ACO.

Dr. Spain, MD, FAAFP, CPC, has worked in family medicine for over 25 years. In 1998, he founded Doc-U-Chart, a practice management consulting firm specializing in medical documentation. Dr. Spain can be reached at sspain@docuchart.com.

Annie Boynton, BS, CPC, CPC-H, CPC-P, CPC-I, RHIT, CCS, CCS-P, CPhT, is the director of 5010/ICD-10 communication, adoption, and training for UnitedHealth Group. She is an adjunct faculty member at Massachusetts Bay Community College, and a developer and member of AAPC's ICD-10 training team. Ms. Boynton frequently speaks and writes about coding, including ICD-10 and 5010 implementation.

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By Kim Cohee, PT, MS, MBA, DPT, OCS

Divide PT and OT Services into Two Categories

Knowing requirements and whether services fall under supervised or constant attendance is important when coding.

Physical therapy (PT) and occupational therapy (OT) service modalities are divided into two categories: "supervised" and "constant attendance." Modalities are typically defined as physical agents intended to effect therapeutic changes (using thermal, acoustic, mechanical, or electric energy). To report these services properly, you must understand the difference between the two types of modalities, as well as the specific requirements for each applicable CPT® code.

Takeaways:

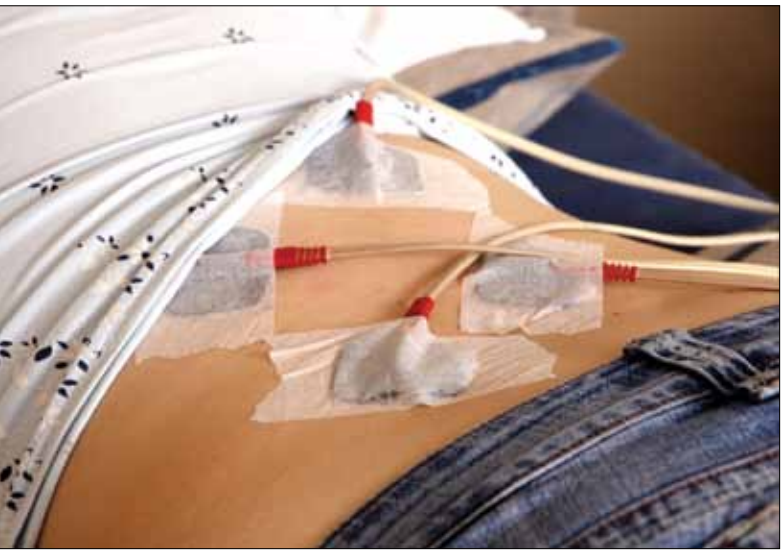
- PT and OT modalities are divided into supervised and constant attendance.
- Supervised services are billed as one unite per date of service.
- Constant attendance services are billed in 15 minute increments with one-to-one care.

Supervised Modalities

Supervised modalities may be billed one unit per date of service. Supervised modalities require neither direct, one-on-one provider-to-patient contact, nor constant supervision. Several of the most familiar supervised modalities include:

97010 Application of a modality to 1 or more areas; hot or cold packs

A hot or cold pack often is used in the beginning or end of a therapy treatment to address pain related to a surgery, injury, or overuse condition. Be sure to document the reason for treatment, the treatment location, and the treatment time in minutes. Medicare designates 97010 as a Status B code, meaning it is always bundled to other provided services. Medicare does not reimburse this code, but other insurers might.



97012 Application of a modality to 1 or more areas; traction, mechanical

Mechanical traction includes cervical and lumbo-pelvic traction. The patient is typically harnessed into a device that applies a distracting force intended to unload a patient's spinal column. Common diagnoses for traction include cervical and lumbar radiculopathies or disc pathologies. The length of treatment in minutes, the location of treatment, and the traction parameters used must be documented.

97014 Application of a modality to 1 or more areas; electrical stimulation (unattended)

Electrical stimulation (unattended) includes Russian, high-volt pulsed galvanic (HVPG), and transcutaneous electrical nerve stimulation (TENS). Therapists use unattended electrical stimulation to alleviate pain as well as to re-train muscles inhibited due to swelling, pain, and immobilization. Common diagnoses would be post surgical conditions such as anterior cruciate ligament (ACL) reconstruction and rotator cuff repair.

Code 97014 is a Status I code; meaning, it is not valid for Medicare. Rather, the Medicare code for unattended electrical stimulation without wound care is G0283 *Electrical stimulation (unattended), to one or more areas, for indication(s) other than wound care as part of a therapy plan of care*. Documentation is the same as for manual electrical stimulation (see below in the Constant Attendance section); electrode placement also should be outlined in the unattended treatment.

97016 Application of a modality to 1 or more areas; vasopneumatic devices

Vasopneumatic device describes a sleeve placed over a swollen limb, such as an ankle, knee, or an upper extremity. The sleeve intermittently fills with air, creating a brief compressive force, with the goal to reduce effusion or edema related to injury or surgery when appropriate. This modality is also useful in treating lymphedema when

Supervised modalities require neither direct, one-on-one provider-to-patient contact, nor constant supervision.

using a lymphedema-specific pump. Documentation should include the parameters with which the device was set to compress and release pressure and the total treatment time. One example of this type of pump is the Jobst pump, but other manufacturers make similar devices.

97018 Application of a modality to 1 or more areas; paraffin bath

Paraffin bath is typically for pain relief in the hands and feet, and uses superficial heat to reduce discomfort in conditions such as arthritis. This service is often provided initially for patient training for use of home devices. It is important to provide documentation regarding medical necessity of this intervention, and why it requires the unique skills of an occupational or physical therapist.

97022 Application of a modality to 1 or more areas; whirlpool

This code includes both wet and dry whirlpools. The modality is intended to decrease pain and muscle spasm, to increase circulation to an injured area (such as the hand, ankle, or wrist), or to clean a wound. Documentation should include the water temperature, the area being treated and time in the water, the type of dressing applied, and any chemicals added to the water.

97036 Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes

Larger whirlpools, called Hubbard tanks, can be used for the full

The constant attendance modality is billed in 15 minutes increments and requires direct, one-on-one provider-to-patient contact.

body, when necessary. This service is reported using 97036. Note that this service requires constant attendance.

Coding for Supervised Services

Clinical Example 1: Patient presents with a diagnosis of right ankle sprain. The therapist chooses to use a Jobst pump for 10 minutes, followed by manual therapy (15 minutes) and therapeutic exercise (15 minutes) for range of motion while in a cold whirlpool. Total treatment time is 40 minutes. Total timed treatment, however, is 30 minutes because only one unit per session can be charged for an unattended modality (and does not include the untimed code time, which is constant attendance, explained below). You should still record the time for the treatment, however. Thirty minutes equals two units of timed treatment, within the time frame of ≥23 minutes to ≤38 minutes.

The therapist cannot bill both the whirlpool and the therapeutic exercise because they are being performed at the same time. One unit of vasopneumatic device, one unit of therapeutic exercise, and one unit of manual therapy are billable, according to the Centers for Medicare & Medicaid Services (CMS) "eight-minute rule."

Documentation should include the patient's position (patient is supine with ankle elevated on bolster), Jobst sleeve placement, compression on and off times (compression for 30 seconds, release for 30 seconds), and total time (10 minutes). Manual therapy should include descriptions of the treatment type (such as grade III joint mobilization), location (right talocrural joint), and for how long.

Constant Attendance

The constant attendance modality is billed in 15-minute increments and requires direct, one-on-one provider-to-patient contact. Such treatments may be billed in multiple units. Examples include:

97032 Application of modality to 1 or more areas; electrical stimulation (manual), each 15 minutes

Electrical stimulation (manual) may involve treatment using a handheld unit for a condition such as Bell's palsy, which affects nerves in the face (note that per National Coverage Determination (NCD) 100-03, section 160.15, Medicare does not cover electrical stimulation for Bell's palsy). TENS placement for the purpose of showing a patient how to use the unit also may be billed with 97032. Documentation should include specifically where the therapist applies the stimulation on the body, treatment time, on and off time if intermittent, intensity/frequency, and patient instructions.

97033 Application of modality to 1 or more areas; iontophoresis, each 15 minutes

Iontophoresis is the use of an electric current to introduce medication into the tissues to reduce pain and edema. The most common medication is dexamethasone—a controlled substance. A physician must write the prescription because therapists are not licensed to distribute controlled substances. The patient gets the medication at the pharmacy and brings it to the therapy visit. The therapist may use the medication as prescribed by the doctor.

Common diagnoses for which iontophoresis is prescribed may include tendonitis, tendonopathies, and bursitis. This is also a constant-attendance modality, but you can't bill for the unit's run time because only one-on-one time with the patient may be billed, and the therapist does not supervise the patient throughout the entire treatment. The total billable time includes only the time spent educating patients about the treatment, prepping them for the treatment, set-up time, and skin check before and after the running of the unit.

97035 Application of modality to 1 or more areas; ultrasound, each 15 minutes

Ultrasound uses high-frequency sound waves to decrease pain, muscle spasm, and joint stiffness with the intention of increasing flexibility. The scientific evidence supporting the efficacy of ultrasound for this purpose is in question, according to the medical evidence using randomized controlled trials. Documentation for ultrasound ideally includes the size of the used ultrasound head, length of treatment time, continuous versus pulsed, intensity, depth of penetration (1 or 3 MHz), and the medication name if doing phonophoresis.

Coding for Constant Attendance Services

Clinical Example 2: A patient is being treated for biceps tendonitis and is experiencing shoulder pain, swelling, and stiffness. The therapist chooses to treat the patient initially with iontophoresis with passive range of motion and postural re-education. A possible billing scenario may be 15 minutes of passive shoulder range of motion, followed by 12 minutes of postural training with exercise instruction, and ending with iontophoresis consisting of five minutes of setup and explanation to the patient, as well as 12 minutes of run time.

The total treatment time is 44 minutes, but based on Medicare's eight-minute rule, only 32 minutes are billable. The therapist should bill for one unit of therapeutic exercise (97110) and one unit of neuromuscular re-education (97112). Per Medicare rules, the iontophoresis is not billable because the setup time is not equal to or greater than eight minutes (even though the run time is).

If the therapist spends 20 minutes on posture re-education, you may bill for two units of neuromuscular re-education and one unit of therapeutic exercise. Because the total timed treatment exceeds 38 minutes, the therapist can bill Medicare three units for 40 minutes (including the five minutes of iontophoresis setup) of total timed treatment.

Documentation for this example needs to include the names of any exercises performed, number of sets and reps, amount of resistance used, position of the patient during each exercise, goal of each exercise, caregiver training and education, and time spent doing the exercises. The iontophoresis documentation should include the name of the medication used, total dose used and the time period, where the electrodes were placed, and the length of the treatment.

Remember: The above example is based on the CMS' eight-minute rule, which may not apply in all cases. Coders should be aware of individual insurance practices regarding therapy billing (iontophoresis is a Status A code for Medicare, and may be paid depending on your payer's local coverage determination (LCD)).

Reimbursement for all of the services mentioned here can vary greatly from payer to payer, and from state to state. Knowing your local policies is critical to getting paid for the care given by providers. On a final note, all modalities should include documentation regarding patient response to treatment.

Kim Cohee, PT, MS, MBA, DPT, OCS, is the manager of the University of Utah Orthopaedic Center Therapy Services. She graduated from the University of Utah with undergraduate and doctorate degrees in physical therapy and a Master of Science in Exercise Physiology. She received her Master of Business Administration from Western Governors University in 2009, and achieved Orthopedic Clinical Specialist (OCS) designation in 2006.

By David Lane, PhD, CHC, CPC, CAPPM

Compliance Is Not a 4-letter Word

Compliance is comprised of four important federal laws to help coders follow an effective program.

Takeaways:

- Compliance is a necessary, integral part of coding.
- Four federal laws form the foundation of a compliance program.
- Laws reinforce the importance of accurate coding, coding standards, and coding participation.

"Compliance" often conjures up images of boring lectures, law enforcement, huge fines, scary "I'm from the government and I'm here to help" mentality, and worse. In reality, compliance is an integral part of the health field. And with health care reform and the Patient Protection and Affordable Care Act (ACA), compliance programs are mandatory.

Compliance is also inextricably linked to coding. With health care reform putting pressure on accurate documentation, coding, and billing, there are many benefits to having strong and accurate coding skills, a positive coding-compliance team, and an effective compliance program to ensure correct reimbursement. Having good partnerships may also strengthen an organization's overall compliance program by increasing a hospital or medical practice's revenue. Finally, coding and compliance working together can support audit or recoupment efforts and quality measurements; and cooperation can help meet electronic health record (EHR) meaningful use requirements.

Fraud. Waste. Abuse.

These three little words form the government's mantra for audits and legal actions conducted by the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), the Office of Civil Rights (OCR), and the Centers for Medicare & Medicaid Services (CMS). As these government agencies look for ways to prevent fraud, waste, and abuse, there are four important federal laws that form the framework for an effective compliance program. Appropriate and effective coding is tied to each of them:

1. **False Claims Act (31 USC§3729).** This Civil War era statute has been revised over the years to strengthen the legal underpinnings and penalties for any individual or entity that presents a false (i.e., inaccurate or wrong) claim to the government (i.e., Medicare or Medicaid or other federal health insurance program). When a submitted claim from a hospital is inaccurate, there is the potential that the False Claims Act is being violated.

2. **Anti-kickback Statute (42 USC§1320a).** This law prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals or generate federal health care program business. This law directly affects referrals from physicians to hospitals for services and patient care.

3. **Stark law (42 USC§1395) or the physician self-referral law.** Stark law is named after the California congressman who spearheaded the massive legislation. This law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship. Given the breadth of this law, any hospital referrals from a physician who receives any form of compensation from that hospital need to be regulated and monitored.

Because hospitals, clinics, and physicians are inextricably linked, it is critical to meet the safe harbors, or exceptions, provided in these comprehensive laws regulating provider-hospital relationships. Huge fines, penalties, Corporate Integrity Agreements (CIAs), exclusion from Medicare, and jail are consequences of violation.

Although typically not directly involved in physician financial arrangements, coders should at a minimum have confidence that all physician/hospital financial arrangements are appropriate. Coders are often the first to see irregular patterns of referrals, elevated service levels, and inappropriate orders—all possible signs of violations. You can ask managers, compliance officers, and legal departments how physician financial arrangements are monitored. When necessary, question any inappropriate or excessive referrals from a particular provider.

4. **Health Insurance Portability and Accountability Act (HIPAA) (45 CFR Parts 160, 162, and 164).** This law, familiar to all coders, governs the transmission of medical records containing important medical information. HIPAA—under the purview of the OCR—also regulates the disclosure of patient protected health information (PHI).

Professional coders know the importance of adhering to strict confidentiality when dealing with the thousands of bits of private medical information coming across their desks each day. With implementation of EHRs, HIPAA kicks in with full force.

The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 increased regulations and requirements for preventing and reporting PHI breaches. For instance, a PHI breach affecting more than 500 patients in one geographical area requires notification to the U.S. Department of Health & Human Services (HHS), notification to affected patients within 60 days of learning about the breach, establishing a specific hotline number for patients to call, and other possible consequences. Data nationally indicates the cost for mitigating and responding to each breach is over $200 per record.

Any misuse of patient PHI can cause the OCR to audit, investigate, and fine the perpetrator. The OCR has initiated over 100 HIPAA audits in 2012 to review practices of hospitals, clinics, and physicians across the United States. More HIPAA audits are probably on the horizon.

These four main laws, along with Medicare and Medicaid rules and regulations, and other state and federal laws, provide tools to guide effective compliance and coding practices. These laws also provide the leverage for the government to audit and review coding practices, patterns, and claims.

You Can't Stick Your Head in the Sand

Historically, coders have said, "I just code what is given me; compliance is not my concern." And in the past, perhaps, knowledge or awareness of some of the aforementioned

With health care reform putting pressure on accurate documentation, coding, and billing, there are many benefits to having strong and accurate coding skills, a positive coding-compliance team, and an effective compliance program to ensure correct reimbursement.

compliance laws were not on the coder's radar.

The landscape has changed. As these laws are revised and updated, deliberate knowledge is being removed as a requirement for violation. Laws now contain the verbiage "known or should have known." For instance, the Anti-kickback Statute is an "intent-based" statute. This means that specific intent to violate the Anti-kickback Statute must be shown to prove a violation. Historically, however, federal courts have interpreted this statute broadly, ruling, for instance, that intent to violate this statute may be inferred from other circumstances.

Conversely, the Stark law is a "strict liability" law. This means that under Stark, lack of deliberate intent or knowledge is not an excuse and proof of intent is not necessary. If there is an improper or illegal physician financial arrangement in place, every referral from that physician is affected as long as the arrangement was noncompliant, and all claims coded and submitted by that physician are suspect.

The False Claims Act was modified in 2009 to make it clearly illegal—defining it as "fraud"—for a hospital or physician to knowingly keep overpayments or money paid to them due to a billing error or wrong payment (i.e., "credit balance"). Entities now have 60 days to repay an overpayment after they know, or should have known, about the improper payment.

In a nutshell: Ignorance of compliance in the changing health care landscape is not bliss. Compliance offices will need to work closely with coding and billing offices to ensure systems and practices are in place to adhere to strict law compliance.

The Government Is Watching

Hospitals and physician practices have seen an exponential increase in government audits and claim reviews. Coders will often be the front end of defense and offense when government auditors review and audit health claims.

The Recovery Audit Contractor (RAC) program is perhaps the most familiar these days, but Medicaid integrity contractors (MICs), Zone Program integrity contractors (ZPICs), Medicare administrative contractors (MACs), and the Comprehensive Error Rate Testing (CERT) program are closely related. All are designed to help the government discern fraud, waste, and abuse—and to recoup federal health care dollars that have been improperly paid.

The U.S. government has repeatedly reported that incorrect claims cost the taxpayers billions of dollars. Consequently, over the past several congressional sessions (both Republican and Democrat led), the OIG enforcement budget has increased dramatically. Government data shows that every dollar invested in compliance recoups anywhere from six to 10 dollars for the government.

The same holds true for third-party payers who have increased their scrutiny of claims, instigating their own independent reviews and audits. From a taxpayer viewpoint, RAC, MIC, MAC, ZPIC, OIG enforcement, etc. are all good ways to ensure Medicare/Medicaid dollars are being paid accurately. But from a hospital or physician practice viewpoint, these programs have added huge administrative burden and costs.

Good News for Coders

The "good news" for professional coders is that these governmental and third-party payer audits reinforce the importance of accurate coding, professional coding standards, and the involvement of coding in an entity's overall compliance program.

One of the key seven elements of an effective compliance program, according to the OIG, is to have regular auditing and monitoring in place. The basis for most audits of claims is the medical documentation, underlying medical necessity, and then how that translates into the codes and the bill. Coders should increasingly be called upon to help review coding internally, set up effective coding practices, protocols, and procedures, and meet accurate coding benchmarks.

David Lane, PhD, CHC, CPC, CAPPM, is chief compliance and privacy officer at Hawaii Health Systems Corporation.

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Melissa Brown, CPC, CPC-I, CFPC, RHIA

Pay for Performance: Go for the Gold

Health care providers will have to get with the program to stay in the game.

As I watched the summer Olympics this past August, I couldn't help but think about the correlation to the trend for "pay for performance," or P4P, we face in health care. The Olympians used various approaches to prepare themselves for the Olympics, but they all had one goal in mind: Gold. In contrast, providers who take a "wait and see" approach toward P4P programs are sure to miss the starting gun.

P4P Is Here to Stay

Several years ago, the Centers for Medicare & Medicaid Services (CMS) introduced the concept of paying for quality services, with the promise of better reimbursement for physicians who reported certain quality measure indicators. The Physician Quality Reporting Initiative (PQRI), which has since become the Physician Quality Reporting System (PQRS), set the stage for a payment system based on quality performance. The goal from the onset has always been to improve patient care and provide better value (quality) for the money being spent on health care (a.k.a., value-based purchasing).

Anyone who has read the latest final rules for various Medicare payment systems can see that P4P is fast approaching (I would argue it's already here). The proposed changes and overlapping goals of PQRS, the CMS Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and the Electronic Prescribing (eRx) Incentive Program make it clear that CMS is intent on rewarding providers who are on board and penalizing those who aren't. And the trend is contagious: A scan of the headlines in health care journals reveals that many private payers are also implementing P4P-based incentive programs.

Patient-Centered Medical Home Is Within Range

Another concept you're sure to hear more about in the coming years is the Patient Centered Medical Home (PCMH) designation, introduced by the National Committee for Quality Assurance (NCQA). The NCQA website describes the PCMH as "a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner." Such medical homes seek to improve patient outcomes by strengthening patient-clinician relationships so clinicians can efficiently deliver the right health care at the right time.

In this Game: Quality vs. Quantity

When looking at these emerging trends, some may claim we are recycling the concept of managed care. Although the basic concepts may be similar, the key difference for these new quality concepts is found in the incentives. The biggest argument against managed care was the perception that patients were denied care due to financial incentives for saving costs. The incentives being introduced now (and just as importantly, the penalties) are tied to the quality of the care, not the volume.

The gold medal winners in these games will be the enterprising providers who started training early, or who are training hard now. These providers are looking to maximize efficiencies among the available programs, and keeping their focus on the true goal: favorable patient outcomes.

Whatever your opinion of P4P programs, they are a reality in our industry, and only those who make the transition from simple data collection to ensuring quality outcomes will go home with the gold.

... CMS is intent on rewarding providers who are on board and penalizing those who aren't.

Melissa Brown, CPC, CPC-I, CFPC, RHIA, is manager of reimbursement and quality improvement, University of Florida Jacksonville Physicians, Inc. She has 20 years of experience in the health care industry. Ms. Brown's areas of expertise include fee analysis, budgeting, and PQRS. She enjoys presenting on teamwork and communication skills. Toastmasters International awarded her its highest honor, Distinguished Toastmaster (DTM). Ms. Brown served as co-director of the annual "Coding on the River" conference in Jacksonville, Fla. for several years and is a past-chair of the AAPCCA board of directors.

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Jacqueline Ann Smith, **CPC-A**
Jagadheeswaran Ganesan, **CPC-A**
Jaime Espino Garcia Jr, **CPC-A**
James Nowacki, **CPC-A**
Jamie Frampton, **CPC-A**
Jamie Midday, **CPC-A**
Jamie Wessel, **CPC-A**
Jan Rae Larson, **CPC-H-A**
Jana Cartelli, **CPC-A**
Janay Monique Appleton, **CPC-A**
Jane B Pilla, **CPC-A**
Jane Daniel, **CPC-A**
Jane M Bauersachs, **CPC-A**
Jane McNulty, **CPC-H-A**
Janenne Johnson, **CPC-H-A**
Janet Hogue, **CPC-A**
Janet Lee Dryden, **CPC-A**
Janette Hughes, **CPC-A**
Janice Martinez, **CPC-A**
Jason Steingisser, **CPC-A**
Jayshree Gade, **CPC-A**
Jeanette Leah Davis, **CPC-A**
Jeanette Vazquez, **CPC-A**
Jeanne Helen McKee, **CPC-A**
Jeffrey Jolicoeur, **CPC-A**
Jeffrey Michael Aull, **CPC-A**
Jeniffer Hilderbrandt, **CPC-A**
Jennie Jimenez, **CPC-A**
Jennifer Ann Miller, **CPC-A**
Jennifer Childress, **CPC-A**
Jennifer Dela Cruz Francisco, **CPC-A**
Jennifer E Marmon, **CPC-A**
Jennifer M Bovie, **CPC-A**
Jennifer Moore, **CPC-A**
Jennifer Northrop, **CPC-A**
Jennifer R Moore, **CPC-A**
Jennifer Roundhouse, **CPC-A**
Jennifer Sensenbrenner, **CPC-A**
Jennifer Thompson, **CPC-A**
Jermeika Burks, **CPC-A**
Jesse Youtsey, **CPC-A**
Jessica Buckner, **CPC-A**
Jessica Lopez, **CPC-A**
Jessica Nichole Bradley, **CPC-A**
Jessica Patillo, **CPC-A**
Jillian Freeland, **CPC-A**
Jinx Dole, **CPC-A**
Joan Sheldon, **CPC-A**
Jo-Ann Senmartin, **CPC-A**
Joanna M Colella, **CPC-A**
Joanne Collier, **CPC-A**
Johanka Fonseca, **CPC-A**
Jordan Costello, **CPC-A**
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Joshua Dann Bables, **CPC-A**
Joyce Seigler, **CPC-A**
Juan Arellano, **CPC-A**
Judith Cantey, **CPC-A**
Julia Linn, **CPC-A**
Julie Ann Grady, **CPC-A**
Julie Arnsdorf, **CPC-H-A**
Julie McCullough, **CPC-A**
Julie Molina Burr, **CPC-A**
Kaitlin Marie Brown, CPC-A, **CPC-H-A**
Kara Brockschink, **CPC-A**
Karen Gosdin, **CPC-A**
Karen Lorene Gravil, **CPC-A**
Karen Weinzirl, **CPC-A**
Karen Wright, **CPC-A**
Karin Reiss, **CPC-A**
Karry Simmons, **CPC-A**
Karyn Anderson, **CPC-A**
Katarena Bermudez, **CPC-A**
Katherine A Poruben, **CPC-A**
Katherine Dionne, **CPC-A**
Katherine Eschenbaum, **CPC-A**
Katherine Marie Root, **CPC-A**
Kathleen Adams, **CPC-A**
Kathleen Love, **CPC-A**
Kathryn Diane Pickering, **CPC-A**
Kathy Held, **CPC-A**
Kathy Mellecker, **CPC-A**
Katie McLaughlin, **CPC-A**
Katryna Marie Pierce, **CPC-A**
Kayla Denter, **CPC-A**
Kayla Lee Sweeley, **CPC-A**
Kayla Nicole Ison, **CPC-A**
Ke'Arra Robinson, **CPC-A**
Ke'aundra Perkins, **CPC-A**
Keith Kisselman, **CPC-A**
Kelley Fusco, **CPC-P-A**
Kelli Daves, **CPC-A**
Kelly Drubert, **CPC-H-A**
Kelly Schaffer, **CPC-A**
Kelly Stenhoff, **CPC-A**
Kendra Gregory, **CPC-A**
Kendra Palsson, **CPC-A**
Kenneth Raymond Gough, **CPC-A**
Keri Minter, **CPC-A**
Keri Nardi, **CPC-A**
Khadija Omar Salisa, **CPC-A**
Kim Beth Craft, **CPC-A**
Kimberly Dawn Barker, CPC-A, **CPC-H-A**
Kimberly Green, **CPC-A**
Kimberly Jubic, **CPC-A**
Kimberly Mason, **CPC-A**
Kimberly Parker-Phillips, **CPC-A**
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Lacey E Palmer, **CPC-A**
Lacey Nicole Lilley, **CPC-A**
Lacey Nicole Ludwig, **CPC-A**
Larissa Sue English, **CPC-A**
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Leefeng Surulinathan, **CPC-A**
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Rhonda Renee Ganal, **CPC-A**
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Richie Hales Urtz, **CPC-A**
Rinna Calagos Payod, **CPC-A**
Rita Alice May, **CPC-A**
Roberta Roth, **CPC-A**
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Robin Lynn Pyles, **CPC-A**
Rochelle Gauthier, **CPC-A**
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Rose Meeks, **CPC-A**
Rosemary Mendoza Tan, **CPC-A**
Roslynn Tharp, **CPC-A**
Roxanne Cox, **CPC-A**
Russ Pedersen, **CPC-A**
Ruth Garber, **CPC-A**
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Ryan Kathryn Asquith, **CPC-A**
Rynard Nickles, **CPC-A**
Sabrina Leigh Foy, CPC-A, **CPC-H-A**
Samantha Fredell, **CPC-A**
Samantha Mae Byram, **CPC-A**
Samantha Maria Beasley, **CPC-A**
Sandra Lea Sconza, **CPC-A**
Sandra M Greenwood, **CPC-A**
Sandy Pedersen, **CPC-A**
Sarah Beth Kane, **CPC-A**
Sarah Gibbens, **CPC-A**
Sarah Lauchlan, **CPC-A**
Sarah Thurston, **CPC-A**
Shamika Lynette DeWalt, **CPC-A**
Shanan Rasmussen, **CPC-A**
Shane Hankerson, **CPC-H-A**
Shane Tewell, **CPC-A**
Shanel Arakawa, **CPC-A**
Shanna Dumas, **CPC-A**
Shannon Denise McCoy, **CPC-A**
Shannon Martin, **CPC-A**
Shannon Morris, **CPC-H-A**
Sharon Bulanadi, **CPC-A**
Sharon Litchfield, **CPC-A**
Sharon Test, **CPC-A**
Sharon VanWinkle, **CPC-A**
Shay Johnson, **CPC-A**
Shelby Peterson, **CPC-A**
Shelby Thrasher, **CPC-A**
Shelley McDaniel, **CPC-A**
Shelley McHugh, **CPC-A**
Shelly Anderson, **CPC-A**
Sherri R Hughes, CPC-A, **CPC-H-A**
Sherry Ann Conner, **CPC-A**
Sherry Brophy, **CPC-H-A**
Sherry D Vaughn, **CPC-A**
Sherry Sullivan, **CPC-A**
Sheryl Anne Peralta, **CPC-A**
Shiela Caasi, **CPC-A**
Shweta Dinesh Patel, **CPC-A**
Sierra Spencer, **CPC-A**
Sivakumar Obulisamy, **CPC-A**
Sonia Hawkins, **CPC-A**
Sonia Worrell, **CPC-A**
Sophy Antony, **CPC-A**
Stacie McIntire, **CPC-A**
Stacy Adams-Neff, **CPC-H-A**
Stacy Wheelwright, **CPC-A**
Stefani Senae Jolley, **CPC-A**
Stephanee Ruiz, **CPC-A**
Stephanie Perez, **CPC-A**
Stephanie Lange, **CPC-A**
Stephanie Leal Maguslog, **CPC-A**
Stephanie Mitchell, **CPC-A**
Subha vaishnavi Srinivasan, **CPC-A**
Sumathi K, **CPC-A**
Summer Becker, **CPC-A**
Suresh Bharathi, **CPC-A**
Susan Brantley, **CPC-A**
Susan Marie Papineau, **CPC-A**
Susana Sarria, **CPC-A**
Susanna Peed, **CPC-A**
Suzanne Peckenpaugh, **CPC-A**
Suzanne Noel Crandall, **CPC-H-A**
Tamara Noe, **CPC-A**
Tamara Shurling, **CPC-A**
Tami Selby, **CPC-A**
Tammie Fish, **CPC-A**
Tammy Farrow, **CPC-A**
Tania Choudhury, **CPC-A**
Tanya Cambpell, **CPC-A**
Tara Ann Beatty, **CPC-H-A**
Tasha J Whitmer, **CPC-A**
Taylor Bachmeier, **CPC-H-A**
Teddy Monacelli, **CPC-A**
Teresa A Bushnell, **CPC-A**
Teresa Greer, **CPC-A**
Teresa Losch, **CPC-A**
Terri Bridegam, **CPC-A**
Tesha Elaine Brock, **CPC-A**
Tessa Margareth Basa Fang, **CPC-A**
Theresa Zimmerman, **CPC-A**
Thursday Reichert, **CPC-A**
Tiffany Nichole Clemens, **CPC-A**
Tina Brilley, **CPC-A**
Tina Marie Miller, **CPC-A**
Toni Margaret Glover, **CPC-A**
Tonisha L Willis, **CPC-A**
Tonya Walker, **CPC-A**
Tori Cunningham, **CPC-A**
Tova Goldstein, **CPC-A**
Tracie Grimes, **CPC-A**
Tracy Jo Schreiner, CPC-A, **CPC-H-A**
Tricia Seibel, **CPC-A**
Trina Trujillo, **CPC-A**
Trish Stratton, **CPC-A**
Ualani Oyama, **CPC-A**
Vanessa Heller, **CPC-A**
Vicki J Bourg, CPC-A, **CPC-H-A**
Vicki J Sommer, **CPC-A**
Vickie Lee Stackle, **CPC-A**
Vicky Kundrick, **CPC-A**
Vivien Hui, **CPC-A**
Wende Michael, **CPC-A**
Wendy Marie Peterson, **CPC-A**
Wendy Sauers, **CPC-A**
Whitney Walston, **CPC-A**
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William Porter, **CPC-A**
William Stewart, **CPC-A**
William Weiand, **CPC-A**
Yael Petretti, **CPC-A**
Yalanda Spence, **CPC-A**
Yetunde Zainab Oriowo, **CPC-A**
Yumei Wiltse, **CPC-A**
Yvonne Marie Elam-Ford, **CPC-A**
Zurima Rodriguez, **CPC-A**

Specialties

Adana Hudgins, CPC, **CEMC**
Andrea Willis, CPC, **CPMA**
Andrew Montaruli, CPC, **CPMA**
Anita Eagan, **CPCD**
Annamarie Kuebbeler, **CPMA**
Anne K Sundquist, CPC, **CPMA**
Annette Baker, **CPMA**
Barb Watkin, CPC, **CHONC**
Barbara Aung, CPMA, **CSFAC**
Barbara Knight, CPC, **CPMA**
Beneka Martine Williams, CPC, **CPPM**
Chris Meola, **CPPM**
Christina Ann Lewis, CPC, **CPMA**
Christina Winters, CPC, **CEDC**
Christine Lynn Stockwell, CPC, **CPMA**
Christine Wernert, **CPMA**
Christy Peek, CPC, **CUC**
Cindy Chao, **CIRCC**
Connie Agenbroad, **CPMA**
Constance M Hunt, CPC, **CPMA**, CIMC
Crystal Euchner, **CHONC**
Cynthia M Pagan, CPC, **CGSC**
Danette L McNulty, CPC-A, CPC-H-A, **CPMA**
Danielle McGregor, **CEDC**
David May, **CPCO**
Deanna Wolken, CPC, **CEDC**
Debra H Brown, CPC, **CPMA**
Debra K Brackbill, CPC, **CEMC**
Denise M Bedard, CPC, **CPMA**
Diana Renee Blankinship, CPC, **CEMC**
Dimple Patel, CPC, **CRHC**
Donna L Christian, **CIRCC**, COSC
Donna McCune, **CPMA**
Donna Waters, **CASCC**
Elizabeth Garza, **CIRCC**
Emma Bik-San Cheung, CPC, **CGIC**
Erica Ortiz, **COBGC**
Erica Woolsey, CPC, **CEMC**
Gina Lynn Tolar, CPC, **CPMA**
Halyn Le, **CIRCC**
Ivonne Cobas, CPC, CPMA, **COBGC**
Jamie Lawler, **CPCD**
Janet Rose Thul, CPC, **CPPM**, CIMC
Jennifer Cole, CPC, **CIRCC**
Jermaine Jay Powell, CPC, **CEMC**
Judy A Wilson, CPC, CPC-H, CPCO, CPC-P, **CPPM**, CPC-I, CANPC
Karen Cadieux, CPC, **CCC**
Kari A Beck, CPC, **CPCD**
Kari Louise Conley, CPC, **COSC**
Karol Koppenhaver, **COBGC**
Katherine Pulley, CPC, **CPPM**
Kathleen A Perkins-Lee, CPC, **CIRCC**
Kathryn J Louisignau, CPC, **CIRCC**
Kathy L Coger, CPC, **CCC**
Kathy M Donald, CPC, **COBGC**
Katie Kirschner, CPC, **CEMC**
Kayce Brook Degenhardt, **CIRCC**
Kellee Michelle Alix, CPC, **CFPC**
Keysha R Jackson, CPC, **CIRCC**
Kimberly A Farley, CPC, **CHONC**
Kimberly B McMahan, CPC-A, **CPMA**
Kolbie A Mangold, CPC, **CPMA**
Kristen Lynn Brazier-Whittico, CPC, **CIRCC**
Latosha Page, CPC, **CEMC**
LeAnne Albright, **COBGC**
Liana Eagan, **CFPC**
Linda Y Warren, CPC, **CPMA**
Lisa Stana, **COSC**
Lisa Maria Archer, CPC, **CPMA**
Lisa Wassemiller, **CPCD**
Lucyma Martinez, CPC-A, **CPMA**
Marianne E Urtel, CPC, **CPMA**, CEMC
Marie Johnson, CPC, **CGIC**
Marilyn Glidden, CPC, **CPMA**
Marisa Austin, CPC-A, **CEMC**
Mary Ann Fanning, CPC, **CEMC**, CFPC
Mary Juanita Galjour, CPC, **CEMC**, CUC
Maureen Kline, CPC, **CPMA**
Melissa Williams, **CEMC**
Michael A Kroll, CPC, **CPMA**, COSC
Michele Buchan, **CHONC**
Michelle Jean Bartoszek, CPC, **CEMC**, CFPC, CIMC
Michelle Mary Watson, CPC, **CEMC**
Myra P Anderson, CPC, **COSC**
Nancy Browner, **CEMC**
Nancy Clark, CPC, **CPMA**, CPC-I
Natarajan Chellamuthu, CPC, **CPMA**
Neang Nhep, CPC, **CPMA**
Norma Ann Panther, CPC, **CIRCC**, CPC-I, CEMC
Norma Fuentes, CPMA
Pamela Ann Wright, CPC, **CGSC**
Pamela Wilson, CPC-A, **CPPM**
Paul Jason Chandler, CPC, CPCO, **CPMA**
Rebecca Lynn Hanif, CPC, **CPCO**
Roberta A Anderson, **CCC**
Robin Martine Cannon, CPC, CPC-H, **CPPM**
Roxanne Lynn DuFort, CPC, **CPMA**, CFPC
Samyuktha Ramalingam, CPC-A, **CEDC**
Sarah E Sparklin, CPC, **CEMC**, CIMC
Sherie Koehler, CPC-A, **CPMA**
Silvia Lassales, CPC-H, CPC-P, **CPMA**
Stacy Buehler, **CEMC**
Stephanie Nowak, CPC, **CEMC**
Suzanna D Decarlo, CPC, **CPMA**
Teresa M Padgett, CPC, **CPMA**, CFPC
Tina Pelc, **CCC**
Tonda Terrell, **CPPM**
Tracy Haas, CPC, **CASCC**
Tricia Martin, CPC, **CGSC**
Trisha A Achtziger, CPC, CPC-H, CPC-P, **CIRCC**, CCC
Trista Jo Helton, CPC, **CEMC**
Trudy Watson, CPC, **CEMC**
Wendy Young Rogers, CPC, CPC-P, **CASCC**

Magna Cum Laude

Aindria Hanks, **CPC-A**
Anusa Mary Samuel Sargunar, **CPC**
Artisha Vassor, **CPC-A**
Charmin Presswood, **CPC-A**
Cherry Rose C Marquez, **CPC-A**
Dacia Marand Spivey, **CPC**
Darshana Jamdar, CPC-A, **CPC-H-A**
Deborah Fuller, **CPC**
Dianne Sibal, CPC, **CIRCC**
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Hanna Wierzchowski, CPC, **CPC-H**
Irma Marrero, **CPC-A**
Izaira Montenegro, **CPC-A**
John Carlo Santos Bulaong, **CPC-A**
Judith Cardin, **CPC-A**
Kathryn Marie Balzer, **CPC-A**
Kelly O'Shea, **CPC-A**
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Marirose Guevarra Go, **CPC-A**
Meaghan Sullivan, **CPC-A**
Melinda Murray, **CPC-A**
Michelle Gort, **CPC-A**
Patti Arredondo, **CPC-A**
Peggy Mireille Goodfield, **CPC-A**
Rebecca Andre, **CPC**
Samantha Jackson, **CPC-A**
Sarah Saulsbury, **CPC-A**
Shahida Parveen, **CPC-A**
Shirley Spieler, **CPC-H**
Skye Ramos, **CPC**
Susan Kay Hohenboken, **CPC**
Tamara Dondie Guice, **CPC-H**
Teya Teon Green, **CPC**
Victoria L Koontz, CPC-A, **CPC-H-A**

A&P Quiz Answer

From page 19: The correct answer is D. The thyroid gland is part of the endocrine system, which produces hormones that coordinate many body activities.

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Rachel Coon, CPC, CPC-P, CPMA, CPC-I, CEMC, CCS-P
Owner of My Coding Connection, LLC., and PMCC Instructor

"Becoming more active in my local chapter and having the support of AAPC has led me to become a much more confident person ..."

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

My aunt, Vera Helton, helped me get a job at a local hospital where she worked. I started my career as a lab transporter and part-time clerk in the medical records department. I went on to work as a unit secretary in a trauma emergency department and later worked for a doctor as an office manager. That position involved billing and coding in addition to accounts receivable. More recently, I worked for Patty Connor as an assistant director of physician coding and reimbursement. Patty encouraged and supported me to continue my professional growth. The last four years, I have been extremely involved with medical documentation and compliance, as well as auditing. This increased my desire to help others become more valuable assets to physician practices. My dream of starting my own business recently became a reality. In November 2011, I started my own business My Coding Connection, LLC. I became a licensed AAPC instructor, teaching the PMCC curriculum and educating about ICD-10. I enjoy helping students realize their goal of becoming a certified coder. Along with the certification classes I conduct, I also audit medical documentation and provide billing and coding workshops. My most recent opportunity to bill for a solo physician motivated me to start another company. I'm excited about this new venture!

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

I served as the Maryville, Ill. local chapter president-elect in 2011 and have moved into the president role this year. Our attendance has increased in our chapter significantly in the past year. I have enjoyed becoming more active in the chapter and helping the chapter grow. Becoming a certified coder and joining AAPC has provided me with many new contacts and opened the door for many life-changing opportunities.

3. What AAPC benefits do you like the most?

I value the opportunity to attend local chapter meetings and gain valuable information from other members; meetings are a great place to network. AAPC supports my efforts by providing many certifications which hold me to a higher standard and strengthen my knowledge. I also like the value of receiving low cost continuing education units (CEUs).

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

I was a shy person when I first began coding. Becoming more active in my local chapter and having the support of AAPC has led me to become a much more confident person who is ready and eager to share knowledge with others.

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

I really love what I do now and I encourage all coders to continue progressing in their careers. I encourage them to consider attaining a Certified Professional Medical Auditor (CPMA®) credential, and if coding is not their strong point, the new Certified Physician Practice Manager (CPPM®) credential is an exciting option. We are fortunate to have many career opportunities as a coder; it is our responsibility to take our careers to the next level.

6. How do you spend your spare time? Tell us about your hobbies, family, etc.

I have been married to my husband, Dale, for 10 years. We have a Pomeranian named "Cheetoh," with whom I like to spend my spare time. Dale and I enjoy camping and fishing, taking walks in the park, and watching movies. The rest of my time is spent doing what I love, working on my business and educating others in the field. CE

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