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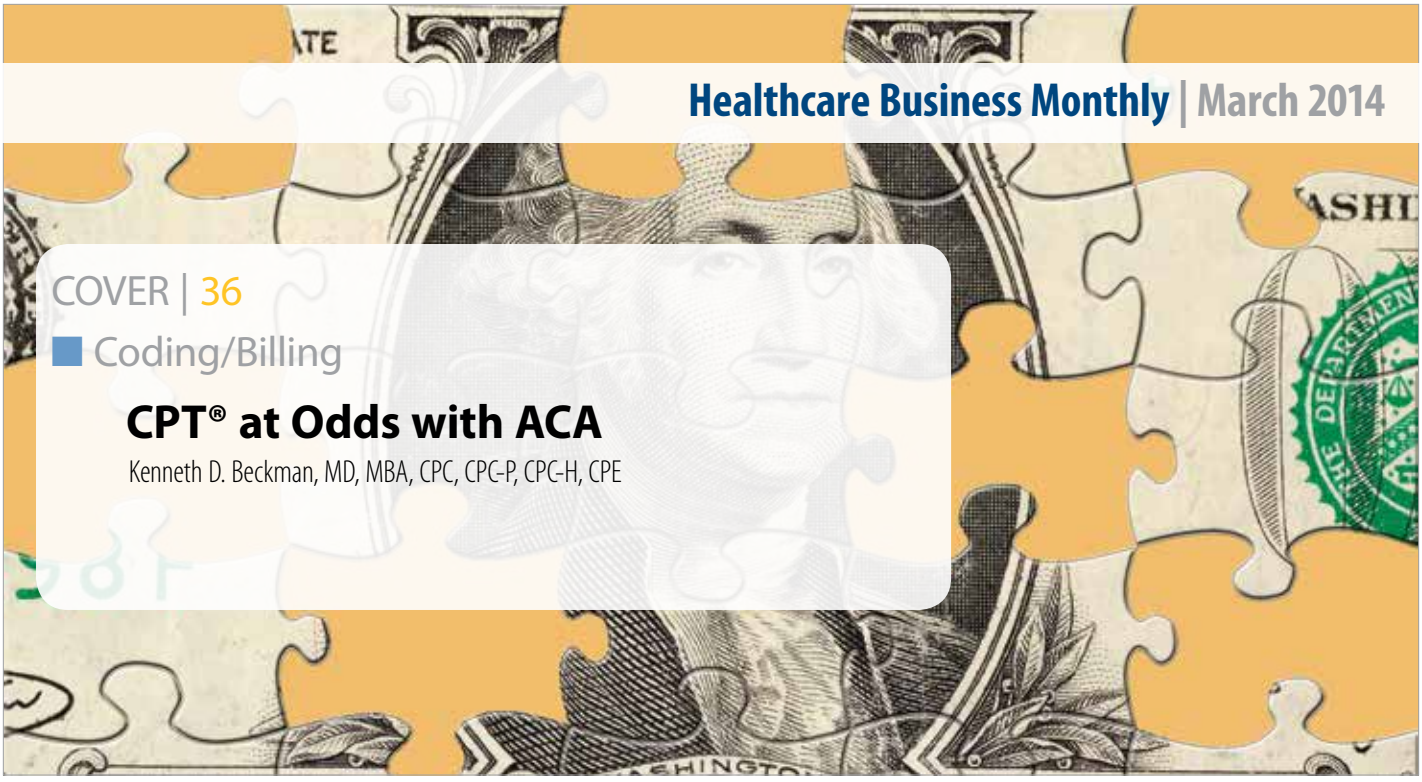

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COMING UP

- Tissue Expanders
- Obesity Treatment
- Patient Health Portals
- Fluid Drainage

Coding/Billing

Auditing/Compliance

Practice Management

DEPARTMENTS

EDUCATION

Online
Test Yourself – Earn 1 CEU
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On the Cover:

When it comes to meeting "first dollar coverage" requirements using CPT®, Kenneth D. Beckman, MD, MBA, CPC, CPC-P, CPC-H, explains how CPT® and the Affordable Care Act are at odds. Cover design by Tina Smith.

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advertising index

Speak Up and Be Heard!

Do you have a question regarding information found in *Healthcare Business Monthly*? Or maybe you have a difference in opinion you would like to share with your peers? Write us at: letterstotheeditor@aapc.com.

HEALTHCARE BUSINESS MONTHLY

Coding | Billing | Auditing | Compliance | Practice Management

March 2014

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Achieving Our Full Potential Together

While AAPC's more diverse and growing membership represents all roles within the healthcare business community, we all seek the same goal of improving the revenue cycle, patients' care, and healthcare as a whole. I'm thankful to be part of a 129,000 member organization where we can work together to do this.

In the race to keep up with the changes to our healthcare system, we reach out to our colleagues in AAPC to help us learn and advance. We look to them in our 527 local chapters for information, mentorship, and networking. We reach out to fellow members from down the hall or across town, in the Coding Discussion Forums on www.aapc.com, via social media, and through those all-important phone calls. We pull together, and we help each other achieve our personal best by sharing information and coaching each other.

Coaching Fosters Improvement

One of my favorite authors is Dr. Atul Gawande, a Boston surgeon who wrote the article "Personal Best" for *The New Yorker*. It's about the criticality of receiving performance feedback from coaches and ongoing training from experts in healthcare. "When the stakes are our lives and the lives of our children, we want no one to settle for average," he said.

Coaching is a key component of ongoing improvement. AAPC's regional and national conferences, such as our national conference, called HEALTHCON, April 13-16, in Nashville, Tenn., are great opportunities to coach and be coached. In addition to more than 50 education sessions and specialty ICD-10 training, AAPC's national conference allows all of us to share and listen, to teach and learn, and to establish professional and personal friendships that help make us all better. They provide everything we need to achieve success.

Coaching Fosters Success

I believe our success improves healthcare in general. I'm taking advantage of visiting local chapters, participating in conferences, and other opportunities to meet and learn from you. I'm excited and grateful for the opportunity to receive your coaching. It helps me achieve my personal best, AAPC achieve its best, and I hope it helps you, as well.

Personally and professionally, in the long run, success is not about just getting oneself across the finish line, it's about helping all those we care about get across the finish line, as well.

Sincerely,

Jason VandenAkker
AAPC CEO

MARCH WORKSHOP

Unlock the Secret to E/M Coding

Medical Necessity Skills for Coders

6 CEUs | 4 hours | Author: Stephanie Cecchini, CPC, CEMC, CHISP, Approved ICD-10 Trainer

Evaluation and management (E/M) codes are the most commonly billed codes. Although there are guidelines to proper E/M code selection, Medical Necessity is the primary driver of correct coding. We are told that a physician may take a full history and provide a full physical, but without medical need to back it up…we should select a lesser code. For example, a resolved contact dermatitis with no other problem or complaint, is not a Level Five service because there is no need for a full Level Five service. It is a coder's responsibility to verify that the diagnosis in the chart supports the procedure being billed. The question becomes: How does a coder, who is not a medical peer, challenge the questions of Medical Necessity when the reason for the services are NOT so black and white? And the largest shade of grey, what supports a Level Three versus a Level Four? This workshop will provide you with the insights necessary to unlock the secret of accurate E/M coding by introducing the skills needed to accurately identify and effectively address Medical Necessity concerns.

This workshop is designed to make the topic of Medical Necessity less intimidating for coders. It also teaches you how to connect with documenting physicians to make E/M coding easier, audit ready, and accurate for fair payment. Maybe even...fun!

In this workshop, you will learn:

- Three little known secrets to accurate E/M coding
- The definitions of Medical Necessity for purposes of accurate coding
- Documentation guidelines
- How to clinically differentiate E/M service levels
- Effective techniques for communication with physicians regarding medical necessity

WORKSHOP FEATURES

- Interactive and hands-on exercises with case studies
- 4-hours includes presentation and skill-building practice
- Comprehensive workbook including presentation slides
- Access on-demand recording

AAPC

Find a workshop location near you and register today at: aapc.com/2014emcoding

2014 Brings Exciting Changes

Here we are, just a few months into 2014, and my New Year's resolutions are already on shaky ground. Even so, I enjoy celebrating a time when I can start over fresh. Here are ways AAPC is staying fresh and ahead of healthcare changes.

Association Rebranding

By now, you've seen a couple of obvious changes at AAPC:

- AAPC's magazine is now *Healthcare Business Monthly*. We are proud of our new look, and know the content changes and updated design will appeal to a much broader and more diverse membership base.
- AAPC National Conference is now HEALTHCON, to more accurately reflect the expansion of our organization into broader areas of healthcare.

Speaking of HEALTHCON, I am really excited about this year's conference because it's in my hometown, Nashville, Tenn. (April 13-16). If you've never been to the Opryland Hotel, you're in for a treat. And if you've never been to an AAPC conference, you're in for an even bigger treat. The National Advisory Board, AAPC Chapter Association, and AAPC conference team are hard at work to make this event the most outstanding ever. There will be many opportunities for you to enhance your education while enjoying an exciting and beautiful setting.

ICD-10-CM Is This Year!

Changing gears a little bit, let's talk about the one big change in 2014 that's on everyone's mind: ICD-10 implementation on Oct. 1. I have some ideas to help with your apprehension, but first I have some numbers to share with you: 9,000, 1,009, and 303.

If at First You Don't Succeed, Try, Try Again

Thomas Edison tried and failed 9,000 times to make the incandescent light bulb, but he eventually created one that worked. At the age of 65, Colonel Harland Sanders was allegedly told "no" 1,009 times before finally franchising and selling his recipe for Kentucky Fried Chicken. Walt Disney failed 303 times to get the financing for a park he wanted to build in California before finally succeeding, and Disneyland was born.

I mention these examples because you're entering a new phase of ICD-10 coding preparation and challenges. Most of you have completed the preliminary training and are now in the first phase of application, when many providers are testing ICD-10 preparedness by adding ICD-10 codes to their ICD-9 coding.

Distinguish Between Learning and Doing

You already may be experiencing the difference between *learning* and *doing*. *Doing* is the sometimes painful reality check, the bench test of how well you have learned what you set out to learn. Scientists tell us failure is the most important part of *learning* and that you learn far more (and retain it for a longer) by failing and overcoming failures than you learn from your successes. Now is the time to do just that: Test and hone your skills, gain confidence, and, yes, fail and learn from those failures.

Learn to Fail Well

Failing *well* begins with removing the *fear* of failure from your thoughts. People who learn to fail well do not let failure overshadow determination. They are empowered by failure rather than being overcome by it. It's important for managers to create and encourage an environment where people can fail and learn from those experiences without fear. Failure is the fire that tempers the steel of resolve and ultimately leads to success.

The Final Step: Proofing

The final step of this process is the most critical: *proofing* the new processes that are in place. Every provider needs to have an objective, authoritative, and reliable way to test (and re-test) the new measures he or she has initiated. For some, it's seeking outside expertise, and for others, it's a combination of proofing methods. Whatever the method, the final test is the accuracy of your efforts.

Make 2014 an amazing year—one of challenge, accomplishment, and personal growth. Nothing of value is ever easy, but together we can accomplish anything—as individuals and as medical professionals.

Take care,

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

Lesion Diagnosis May Be Payer Dependent

The October 2013 article "Skin Lesion Excisions: Three Answers in the Report Will Help You Piece Together the Coding Puzzle" (pages 40-42) states:

Per *ICD-9-CM Official Guidelines for Coding and Reporting* (chapter 2: Neoplasms), "To properly code a neoplasm it is necessary to determine from the record [e.g., pathology report] if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior." I have two comments about this statement.

First, I want to clarify that "[e.g., pathology report]" is the author's interjection, as indicated by the brackets. ICD-9 guidelines *do not specifically require* a pathology report as the document of record to determine the classification of a neoplasm.

Secondly, some payers may require skin lesion excision claims to be coded with the diagnosis at the time of the procedure, rather than what is on the pathology report. For example, the local coverage determination (LCD) for Skin Lesion Removal for CMS Jurisdiction F states, "… proper coding requires the highest level of diagnosis known *at the time the procedure was performed* …" [emphasis added] (Medicare Coverage Database at www.cms.gov).

I suggest you remind coders to check with their local carriers for guidelines when coding for specific scenarios.

Jeannie Ryder, BA, CPC, CEMC

Your comments are accurate and well made. Although the pathology report is always a safe bet, you may likewise report a diagnosis that the provider has properly documented and confirmed in the patient record for the encounter in question. If provider documentation lacks sufficient detail or includes potentially conflicting information, you should ask for clarification rather than risk reporting a "rule out" or "suspected" diagnosis—which may, for instance, label the patient with a malignancy that he or she does not, in fact, have.

Specific payer guidelines and contract requirements are the ultimate authority on coding and claims processing, and coders are always wise to check with their individual payers when coding specific scenarios. Note, however, that payer requirements may conflict with American Medical Association (AMA)/CPT® and/or ICD guidelines, as is the case with the LCD referenced. Per *ICD-9-CM Official Guidelines for Coding and Reporting*, "For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses."

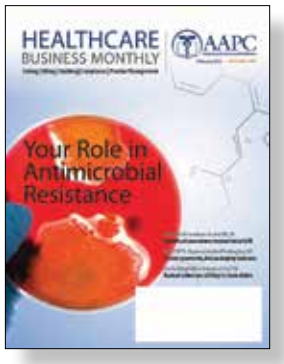
If your payer specifies requirements contrary to generally recognized coding standards, be sure to confirm the instructions *in writing*, and keep them on hand to defend your claims against any potential look-backs.

Healthcare Business Monthly

Lund-Browder Chart Correction

On page 27 of the February issue, the "Lund-Browder Classification Method Chart" reproduced from the CPT® codebook includes an error. In the "Birth-1 year" column, the right thigh is listed as 2.5 percent; the correct number is 5.5 percent (the same as the left thigh).

Peripheral Line Differs from Arterial Puncture



On page 28 of the February issue, the article "Account for Complex Procedures in the ED" includes an error. The text reads:

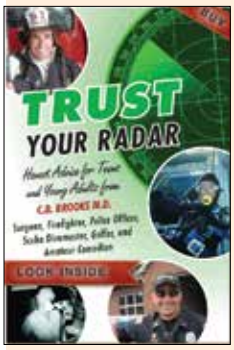
"Note that a line placed in the external jugular vein is considered a peripheral line and is reported using CPT® 36600 *Arterial puncture, withdrawal of blood for diagnosis*. This service is not separately billable if the physician reports critical care (e.g., 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*)."

The appropriate code for a peripheral line is 36000 *Introduction of needle or intracatheter, vein*.

Kudos

Please send your kudos to:
kudos@aapc.com

Good, Honest, and Inspirational



Chris Leber, MD, CPC, has taken his credentials and expertise in an entirely different direction than the average Certified Professional Coder (CPC®). He has written two self-help books for teenagers and young adults: *Trust Your Radar* and *Trust your Radar, Slackers' Edition* (www.TrustYourRadar.com). The books are written from the perspective of a parent, surgeon, firefighter, police officer, scuba divemaster, golfer, and amateur comedian. According to Leber's website, his books contain "Honest advice about personal safety, health, decision making, savings and debt, driving, and how to identify good people—and avoid bad ones."

Kudos, doctor, on the publication of your motivational books!

ACOs Pay Off for Some

Results for Accountable Care Organization (ACO) efforts under the Affordable Care Act show decreased spending for Medicare, but not much in the way of bonus payments for participants. The goal of ACOs is to coordinate patient treatment among providers to reduce unnecessary care, improve health outcomes, and ultimately reduce government spending.

Participating hospitals and physicians are awarded a percentage of the money they save only when quality care and health spending meet Medicare targets.

The Centers for Medicare & Medicaid Services (CMS) Innovation Center launched a Pioneer ACO model in 2012, resulting in:

- After its first year, nine of the 32 participating organizations exited the program.
- Nine of the remaining 23 organizations saved money.

Of the 114 organizations who participated during the first 12 months of participation in 2012:

- A little more than half did not reduce health spending to reach below targets, and the rest slowed health spending slightly.
- Out of the participants who did not meet targets, 29 reduced spending enough to keep some of their savings.

The downside for 114 participating ACOs:

- Five did not report quality data and two of those won't get bonus payments.
- Four may have to return money to Medicare for exceeding spending targets.
- Two may owe CMS because they did not slow spending.

Since its inception, ACOs have expanded to 340 participating organizations.

CMS said it isn't surprised by the results because the ACO program is designed to foster long-term savings. The program has showed to reduce Medicare spending, while improving quality of care, despite inconsistent results. CMS also said that Medicare plans to keep $128 million from the first year and share $126 million of that with ACOs.

For more information regarding ACOs, go to http://innovation.cms.gov/initiatives/aco/.

Source: Modern Healthcare, "Providers net uneven results from ACO experiment," Jan. 30, 2014.

NCD Quarterly Release Includes ICD-10 Translations

To better prepare for this year's ICD-10 implementation, CMS provided ICD-10 translations in the April 2014 quarterly release of the edit module for clinical diagnostic laboratory services. The changes are effective for services on or after April 1, 2014 (for ICD-9) and Oct. 1, 2014 (for ICD-10).

The quarterly release notifies Medicare contractors of laboratory edit module updates in the laboratory national coverage determination (NCD) code lists for April 2014. The translations are for NCDs 190.12 - 190.34.

Download the changes at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2852CP.zip.

Source: Change Request 8585 at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2852CP.pdf

By Faith C. M. McNicholas, RHIT, CPC, CPCD, PCS, CDC

Core A and Core B: Music to Your Career

Continuing education units (CEUs) keep your professional credentials in tune.

photo by iStockphoto ©dansvero

Professional musicians excel at playing one particular instrument, but often are capable of playing several others. For example, a classical pianist might also be an accomplished guitarist. To maintain that secondary proficiency, she may take guitar lessons to improve fretting and strumming skills, but she must also constantly practice playing the piano to keep her core skills fine-tuned.

You can apply that analogy to explain why keeping up with both Core A and Core B CEUs is so important for AAPC credentialed members.

Get to the Core

Core A focuses on work/activities that AAPC credentialed members do at the core of their daily practice. If coding is your primary job responsibility, AAPC-approved continuing education courses that relate to coding and billing are considered Core A of your core educational content. Continue Education Units (CEUs) must be comprised primarily of Core A educational content to show competency. AAPC-*approved* Core A CEUs must comprise no less than 66 percent (2/3) of the total CEUs earned per CEU period.

Educational course content that helps a Certified Professional Coder (CPC®) improve other skills (communication, time management, stress) is considered Core B. Education topics and content that are not core to a member's certification can comprise no more than 33 percent (1/3) of the total CEUs earned in the reporting period.

Earning both Core A and Core B CEUs can help with job performance and advancement preparation. To maintain CPC® and specialty credentials, AAPC requires you to earn CEUs with core education content to show competency. If one core credential is held, 12 of the 36 total CEUs due every two years may be obtained from Core B core education content.

The following are examples of core education content that fulfills Core A CEUs:

Coding/Billing Core Content:

- CPT®
- ICD-9-CM (Vols. 1-3)
- ICD-10-CM
- HCPCS Level II
- Coding and billing policy and procedure

Clinical Core Content:

- Anatomy
- Physiology
- Medical terminology
- Pharmacy
- Pathophysiology

Compliance Core Content:

- Compliance auditing
- Compliance planning
- Self reporting
- Compliance training

Regulatory Core Content:

- Medicare regulations
- Medicaid regulations
- Office of Inspector General Work Plan
- The Centers for Medicare & Medicaid Services (CMS) transmittals
- Teaching regulations
- National and local coverage determinations

Data/Claims Core Content:

- Data management
- Account receivables management
- Appeals
- Revenue cycle

Insurance Core Content:

- Payer contract negotiations

The following are examples of education content that fulfills Core B CEUs:

Professional Self Improvement Core Content:

- Communication skills
- Management skills
- Time management
- Stress management
- Employee issues
- Occupational Safety and Health Administration
- Workers' compensation benefits
- The Joint Commission

Exception: Core B topics focus on practice management responsibilities. Limitations are not enforced for the Certified Physician Practice Manager (CPPM®) certification.

Obtain AAPC-approved CEUs

The most effective, least expensive way to obtain AAPC-approved CEUs is through regular attendance at local chapter meetings. Chapter officers request approval from the AAPC CEU Vendor Department for all chapter meetings to be assigned with an in-

By Brenda Edwards, CPC, CPB, CPMA, CPC-I, CEMC; Barbara Fontaine, CPC; and Donna Nugteren, CPC, CEMC

Together, Officers Complete the Local Chapter Puzzle

Officers are the puzzle pieces of your local chapter. To complete the picture, all the pieces must be accounted for and fitted together.

The *Local Chapter Handbook* gives a full description of expectations and duties of chapter officers. All officers have specific assignments, and must realize how their individual assignments (pieces) fit into the bigger puzzle. A chapter without this cooperation becomes disjointed, and moving ahead often becomes impossible.

Here's how to make sure your chapter uses all of its puzzle pieces.

Structure with Corner Pieces

Organize the pieces, determine the boundaries and outside borders, and place the corner pieces (your president). Under the guidance of the *Local Chapter Handbook*, your president brings all the officers together to ensure they understand their duties and leads the way to the finished picture. He or she sees the entire puzzle, but can focus on each piece as it's built. This leadership makes chapter members feel like part of a well-structured, fun organization.

Build the Frame

The vice president, secretary, and treasurer are the side pieces that hold the puzzle all together, making the perfect frame. These officers all follow strict guidelines under the direction of the president to ensure your chapter stays true and on a straight path. The inside pieces of the puzzle, however, come in many shapes and sizes to create variety. For example, officers can fill the inside pieces of your chapter's puzzle with a fun game night, networking, small group activities, and speakers.

Complete the Picture

Not every chapter is large enough to elect a dedicated education officer or member development officer. These individuals are the inside "wavy" pieces that fill in the gaps of your puzzle. They assist the other officers to find good programs, welcome new members, or mentor. If your chapter doesn't have these officers, you can form a committee to help with these tasks. For example, find someone to draft a newsletter, to furnish refreshments or door prizes, or to keep your chapter history.

Each chapter is unique and held together with the time and effort your members commit to completing your chapter's puzzle. Encourage your members to help assemble the pieces because, just like solving puzzles, chapter involvement is addicting! HBM

Earning both Core A and Core B CEUs can help with job performance and advancement preparation.

dividual catalog number, which indicates an AAPC CEU seal of approval. Note that CEUs are not awarded retroactively.

You can also receive educational content from other institutions, such as the Centers for Medicare & Medicaid Services (if it's pre-approved by the AAPC CEU Vendor Department and a catalog index number is issued to confirm approved CEUs).

Another way to earn CEUs is to review *Healthcare Business Monthly* for answers to the associated Test Yourself quiz posted on the AAPC website for every issue. Please note that CEUs earned from this publication are counted based on the issue date and not the date of completion.

Aim High

AAPC aims to ensure all of its credentialed members maintain the highest caliber of professionalism through continuing education. By maintaining your core requirements, you'll soon become a maestro in the business of healthcare.

For more information on core education requirements, visit www.aapc.com/medical-coding-education/help/index.aspx. HBM

Faith C.M. McNicholas, RHIT, CPC, CPCD, PCS, CDC, has experience in solo and group practice medical specialties. She is assistant editor for American Academy of Dermatology's (AAD) Derm Coding Consult, and a contributor for Association of Dermatology Managers/Administrators (ADA/M) newsletter and Journal of Dermatology Nurses Association (JDNA). McNicholas presents at AAD annual and summer meetings, AAPC regional conferences, ADA/M and JDNA annual meetings, and AAD monthly webinars and regional symposia. She is an ICD-10-CM/PCS expert and approved trainer and a past president, president-elect, and secretary of the Des Plaines, Ill., local chapter.

By Angela Clements, CPC, CEMC, COSC

Chapter Building Blocks: Mentoring and Networking

Get more out of AAPC local chapter meetings than CEUs.

photo by iStockphoto® Stask

I am an advocate for AAPC local chapters and here's why:

I attended my first local chapter meeting while in college. My coding class was at night, and once a month it occurred on the same day that the New Orleans local chapter held their meetings. My teacher (advisor) attended these meetings and encouraged me and my fellow classmates to become AAPC members and attend chapter meetings, as well. I did, and that's where I learned the importance of mentoring and networking.

The Meaning of Mentorship

To realize the benefits of mentorship, you must first look at its core meaning:

> **Mentorship** *is a personal developmental relationship in which a more experienced or more knowledgeable person helps to guide a less experienced or less knowledgeable person. True mentoring is more than just answering occasional questions.*[1]

Note the word "relationship" in this definition. A true mentorship requires a connection between two people. That's where the importance of attending local chapter meetings comes into play. Members who attend chapter meetings on a regular basis develop true relationships.

Realize the Importance of Mentoring

When you are fresh out of school with no coding experience, you are excited about earning your Certified Professional Coding (CPC®) or Certified Professional Coding–Apprentice (CPC-A®) credential and you cannot wait to start working. That excitement quickly fades, however, if no one will hire you due to lack of experience. Many new coders attend meetings every month hoping to speak with someone who can offer them encouragement and advice.

Mentoring Relies on Experienced Coders

If you are a seasoned coder, you are instrumental in the development of new coders in this profession and your attendance is essential at chapter meetings. It's not about what you can get out of meetings; it's about what you can offer your chapter and its members. At the very least, you can offer the wisdom of your successes and your failures.

Sometimes my favorite part of the day is when I bounce information off fellow coders while deciphering a difficult case or determining how to code a new procedure. It's a great feeling to know I am not alone, spinning my wheels.

My mentor was my college advisor. She guided me through the education process and, 15 years later, she still encourages me, congratulates me, guides me, listens to me, and offers assistance. She is someone in the coding profession who I know I can always count on when I need advice. I am indebted to her for my professional success. Although there are many others who have fostered my growth, she was my initial contact and remains a constant mentor.

The Meaning of Networking

Now let's look at the definition of "networking":

> **Networking** *is the exchange of information or services among individuals, groups, or institutions; specifically: the cultivation of productive relationships for employment or business.*[2]

There's that word again: "relationship." Establishing relationships isn't easy even in the best of circumstances, but it's nearly impossible if you're a remote coder. Without face-to-face interaction with co-workers on a daily basis, it's vital that you have a network of peers who you can contact for guidance or advice. Once again, local chapter meetings are the best place to establish contacts and to build a solid network.

Realize the Importance of Networking

Networking involves making connections with those who can help you with a difficult case or with whom you can share your successes.

It's a great feeling to know I am not alone, spinning my wheels.

Networking not only benefits the individuals involved, but also the organization to which they belong.

According to Adam Small, founder of the Strategic Business Network, "NETWORKING is the single most powerful marketing tactic to accelerate and sustain success for any individual or organization!"

Step Up to the Challenge

Most chapters meet for a couple of hours, once a month. That's a small investment to foster growth in others, as well as yourself. I'd call that a profitable return! Think of the people you will meet, the friendships you will form, and the information you will obtain to assist with your personal and professional growth—that which you can use to nurture growth in others.

Seasoned coders: Become a resource for up-and-coming coders. Make others fall in love with coding and become as passionate as you are about it. Attend your next local chapter meeting, and make a world of difference in someone's life. HBM

Angela Clements, CPC, CEMC, COSC, is an internal consultant in the Coding and Education Department at Ochsner Health Systems in New Orleans, with 15 years of healthcare experience in multi-specialty. She is a member of the AAPC National Advisory Board for Region 5 and member development officer of the Covington, La., local chapter.

1 http://en.wikipedia.org/wiki/Mentorship
2 http://www.merriam-webster.com/dictionary/networking

By Kathy Burke, CPC, CPB

Gear Up for May MAYnia

It's time to start thinking about how you'll showcase your chapter in May.

May MAYnia is just two months away. Now is a good time to start planning how your local chapter will celebrate and roll out the welcome mat to guests and prospective members.

Prizes, Prizes, and More Prizes!

Prizes are awarded to the chapters with the greatest number of guests and percentage of chapter members in attendance at May MAYnia meetings. Profession-specific prizes from AAPC and other vendors may include webinars, code books, how-to books, tote bags, etc. The AAPC Local Chapter Department also provides free giveaway items to all chapters that schedule meetings in May; in the past, these items included sticky note pads, coasters, nail files, and pens. Many chapters also give members more customized tokens of appreciation, such as calendars marked with upcoming events and copies of the chapter newsletter.

Advancing Healthcare

As AAPC membership expands, so does the diversity of its members. These days, coders are in good company at meetings with practice managers, billers, auditors, compliance officers, and other healthcare business professionals. You'll see at HEALTHCON in April that AAPC is making a concerted effort to advance the business of healthcare.

Your chapter's annual May MAYnia is an excellent opportunity to engage and connect professionals in your area, as well. When preparing for May MAYnia, consider choosing presenters and topics with an appeal to a broad audience of healthcare professionals. During this all-important year of ICD-10 implementation, everyone involved in the business of healthcare will have more reasons than ever to connect and work together!

Get Creative!

AAPC's local chapters have a history of creating fun and exciting programs. For some chapters, May MAYnia serves as a member appreciation event, including chair massages, themed prizes, raffles, and delicious food. Other chapters hold their annual seminar during the month of May to give their members an extra boost in continuing education units (CEUs). Inviting a national speaker is a great way to introduce prospective members to the high-quality educational programs available through AAPC.

Other tried and true ideas include:

- Inviting a motivational or inspirational speaker to present topics such as communication skills or stress management, which appeals to a broad audience (see this month's AAPC Chapter Association article, "Core A and Core B: Music to Your Career," for other topic ideas).
- Playing coding games that get everyone engaged.
- Creating opportunities for your guests to experience the power of networking.

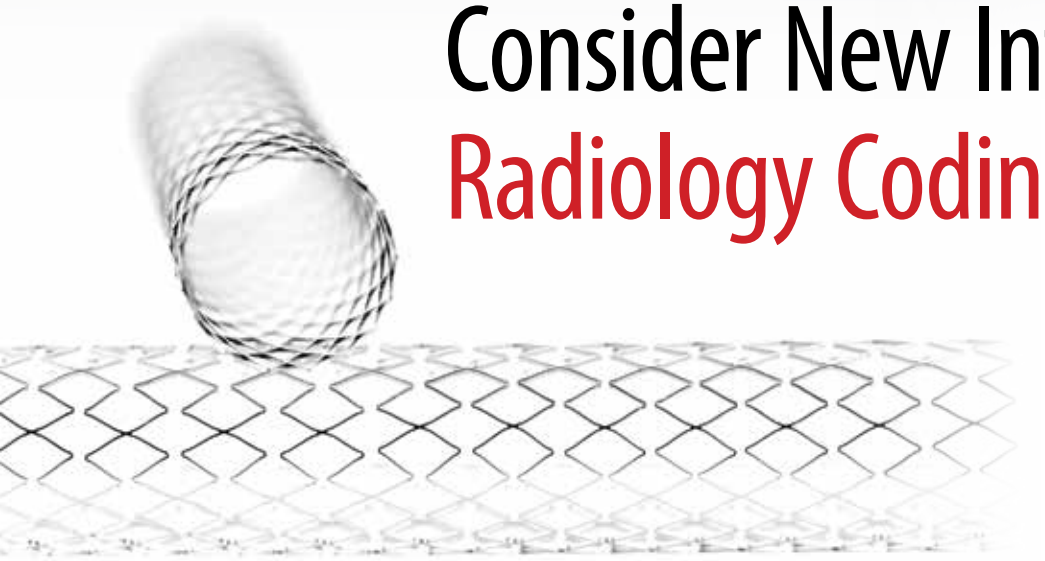
Spring to Your Local Chapter

Encourage chapter members to start planting seeds with colleagues and co-workers about coming to the May MAYnia meeting. Reach out to instructors and students from local colleges to make sure they know about the meeting, as well. Connect with chapter members via email and your local chapter forum to provide a heads up for what's in store. Spring is a time of renewal and growth—the essence of what May MAYnia is all about! HBM

Kathleen R. Burke, CPC, is interim manager of HIM Coding for Tucson Medical Center and the 2013-2014 AAPC Chapter Association board of directors, Region 7 representative.

By David Dunn, MD, FACS, CIRCC, CPC-H, CCVTC, CCC, CCS, RCC

Consider New Interventional Radiology Coding Concepts



Significant changes—including code deletion and new bundling concepts—are critical to know for accurate coding.

CPT® 2014 includes significant changes to interventional radiology (IR) coding. This article will discuss code changes related to stenting, fenestrated stent grafts for repair of visceral aorta, embolizations, drainage procedures, and breast biopsies. We'll also take a quick look at new Category III codes for renal sympathetic denervation and pulmonary tumor ablations.

Editor's note: Because of the number of codes and the richness of their nomenclature, which would take a good deal of extra space, we have paraphrased the code descriptions in this article. A glossary is provided on page 20. Please consult your CPT® 2014 codebook for the official descriptions.

Stents

For 2014, there is one new code (37217) for common carotid or innominate stent placement, when performed via a carotid cut-down.

Notes:

- Ipsilateral catheter selection and imaging is bundled to 37217.
- Angioplasty within the deployment zone is bundled to 37217.

Example: In the operating room, the cervical carotid is exposed via an incision. A puncture is made, and angioplasty followed by stent placement in the innominate stenosis is performed.

Proper coding is 37217, which includes the open exposure, catheter selection, angioplasty, and stent.

The remaining stent code changes relate to non-carotid, non-vertebral, and non-lower extremity stent placements.

Codes 37205-37208 and 75960 are deleted. New, replacement codes are 37236 for the initial stent placement in the artery and +37237 for each additional artery; and 37238 for the initial stent placement in the vein and +37239 for each additional vein.

Notes:

- Use these codes for either open or percutaneous approach.
- Codes include access creation and routine closure.
- Supervision and interpretation (S&I), guiding, and completion imaging are included.
- Angioplasty within the stent area, or within the same vessel that is stented, is not additionally reported.
- Code per vessel treated (not per lesion or per stent placed).
- You may report catheter selections and first-time diagnostic angiography.
- You may report intravascular ultrasound (IVUS) when performed.
- You may report ultrasonic guidance for access when performed and documented appropriately.
- Only one initial arterial and/or venous stent is reported per encounter.
- Bridging lesions between two vessels are reported with one stent placement.
- Report stent if used as the sole treatment for aneurysm, pseudoaneurysm, or vessel trauma.
- Do not code for stent if used to facilitate vessel occlusion with other embolization techniques, such as coils.

Example: A patient has bilateral, severe subclavian artery stenosis.

For fenestrated visceral aortic endografts, catheter placements within the graft deployment zone are bundled, but catheter placements outside of the deployment zone may be reported separately.

Via a common femoral approach, the bilateral stenoses are angioplastied, followed by a stent placement in the left subclavian artery.

Proper coding is 36216, 36215-59, 37236 for the left subclavian angioplasty (included) and stent, as well as 35475 and 75962 for the right subclavian angioplasty.

Fenestrated Visceral Endograft

Category III endovascular repair codes 0078T-0081T are deleted. New, replacement codes for repair of visceral aorta by deployment of a fenestrated visceral aortic endograft are:

34841 Repair of visceral aorta; including one visceral artery endoprosthesis

34842 including two visceral artery endoprosthesis

34843 including three visceral artery endoprosthesis

34844 including four or more visceral artery endoprosthesis

If the anatomy requires placement of the fenestrated graft through the infrarenal aorta into the common iliac arteries, you will select from the following new codes:

34845 Repair of visceral aorta into the common iliacs; including one visceral prosthesis

34846 including two visceral artery endoprostheses

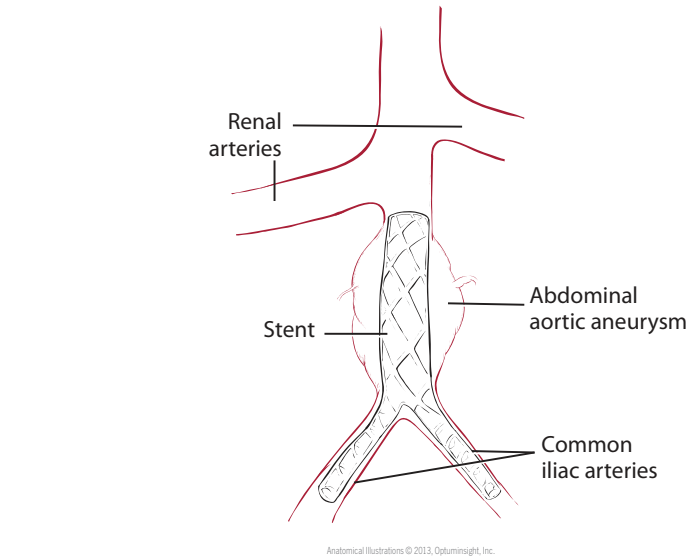
34847 including three visceral artery endoprostheses

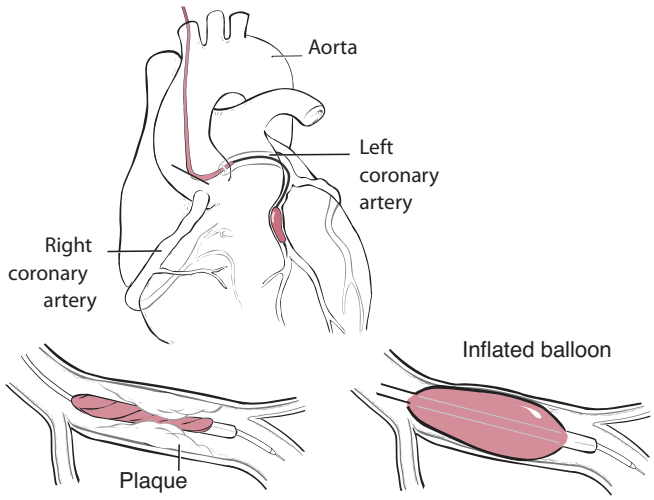
34848 including four or more visceral artery endoprostheses

These codes are for the repair of abdominal aortic aneurysm, pseudoaneurysm, dissection, penetrating ulcer, hematoma, or disruption. The visceral aortic vessels include the celiac, superior mesenteric artery (SMA), and renal arteries.

Notes:

- Do not use 34841-34848 for chimneys, snorkels, or periscope procedures.
- Imaging and angioplasty/stent placement within the deployment zone is bundled.





- Catheter placements within the graft deployment zone are bundled, but catheter placements outside of the deployment zone may be reported separately.
- Extensions that terminate distally in the common iliac artery (CIA) and/or proximal aortic extensions are bundled.
- If performed, extensions into the internal or external iliacs or common femoral may be reported using 34825, 75953, 34826, or 75953-59.
- You may separately report embolization if performed.
- You may report 34812 for open approach when performed.

Example: Via a cut-down of the right common femoral and percutaneous access of the left common femoral, a fenestrated endograft is deployed from the suprarenal aorta extending into the common iliacs. Through fenestrations in the graft, three endoprotheses were deployed into the renals and the SMA.

Proper coding is 34847 and 34812 because the graft extended into the common iliacs, and three visceral endoprostheses were deployed. Only one cut-down (34812) was performed, on the right.

Embolizations

Endovascular embolization is used to treat abnormal blood vessels. Embolization codes 37204 and 37210 are deleted. The new codes for 2014 are:

37241 Non-hemorrhagic venous abnormalities (i.e., venous malformation, hemangioma, varicocele, dialysis fistula side branches)

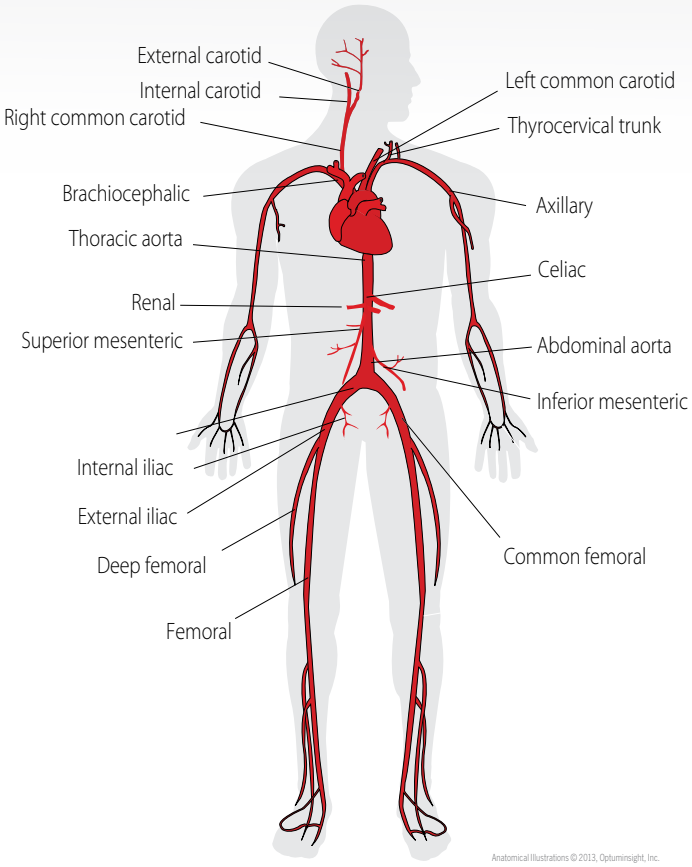
37242 Non-tumor and non-hemorrhagic arterial abnormalities (i.e., arteriovenous malformations (AVM), aneurysm, arteriovenous (AV) fistula)

37243 Tumors or organ infarction (i.e., benign or malignant tumors, including uterine fibroids)

37244 Hemorrhagic arterial, or venous or lymphatic, extravasation (i.e., hemorrhage related to postpartum, gastrointestinal, trauma; Thoracic duct for chylous effusion)

Notes:

- There are no changes to codes for central nervous system (61624) or head and neck (61626) embolizations.
- There may be overlap in the new codes; choose the appropriate code based on the primary reason for the current embolization procedure.
- You may separately report diagnostic angiography and catheter placements.
- Report only one embolization code per surgical field.
- S&I is included in the new embolization codes; do not report 75894 with 37241-37244.



- Follow-up embolization angiography is included in the new embolization codes; do not report 75898 with 37241-37244.

Example: A patient presents with significant hemorrhage secondary to the rupture of a splenic artery aneurysm. Coils are placed in the splenic artery, with occlusion noted on the follow-up angiogram. Report 37244 because the primary indication is hemorrhage (by contrast, 37242 is for arterial abnormality (aneurysm)). The follow-up angiogram (75898) is bundled; you may not report it separately.

Drainage Procedures

Abscess drainage codes 32201, 44901, 47011, 48511, 49021, 49041, 49061, 50021, and 58823 are deleted. The new codes are:

10030 Image guided drainage by catheter; soft tissue

49405 Image guided drainage by catheter; visceral (not for thoracentesis, pleural drainage, or cholecystostomy)

49406 Image guided drainage by catheter; peritoneal or retroperitoneal, percutaneous approach (not for paracentesis or peritoneal lavage)

49407 Image guided drainage by catheter; peritoneal or retroperitoneal, transvaginal or transrectal approach

Notes:

- These codes are specific to the drained anatomical area as well as the approach.

> Report only one embolization code per surgical field.

For breast procedures, the placement of markers is bundled with percutaneous biopsies.

- Code for each drained collection with a separate catheter.
- The new, image guided drainage codes bundle all imaging; do not additionally report 75989, 76942, 77002, 77003, 77012, or 77021.

Example: A percutaneous puncture is made under ultrasound guidance into a subcutaneous abscess in the right thigh. Purulent material is obtained and a catheter is left. Proper coding is 10030, which includes the imaging.

Breast Procedures

Breast biopsy codes 19102, 19103, 19290, 19291, 19295, 77031, and 77032 are deleted. New codes are:

19081 Percutaneous breast biopsy; first lesion, with stereotactic guidance
+19082 each additional lesion, stereotactic
19083 Biopsy; first lesion, with ultrasound guidance
+19084 each additional lesion, ultrasound
19085 Biopsy, first lesion, with magnetic resonance imaging (MRI) guidance
+19086 each additional lesion, MRI

Notes:

- Imaging guidance is bundled to codes 19081-19086.
- If performed, specimen radiograph (76098) is bundled.
- For breast procedures, the placement of markers is bundled with percutaneous biopsies.
- Use add-on codes for additional biopsies when the same imaging modality is used.
- Use another primary code if an additional percutaneous biopsy is performed with a different imaging modality.

Example: A percutaneous breast biopsy is performed with stereotactic guidance of a solid mass in the left breast, with a clip also placed to mark the site. This is followed by percutaneous breast biopsy with ultrasound guidance performed in a separate breast lesion in the left breast.

In this case, you'd report both 19081 and 19083 because different imaging modalities were used. The clip is bundled, as is the imaging guidance.

There are also new codes for breast marker/device placement for localization (when performed without a percutaneous image-guided breast biopsy). Markers might include clips, wires, needles, or seeds/pellets:

19281 Percutaneous placement of breast localization device(s); first lesion, mammographic guidance
+19282 each additional lesion, mammographic
19283 Device placement; first lesion, stereotactic guidance
+19284 each additional lesion, stereotactic
19285 Device placement; first lesion, ultrasound guidance
+19286 each additional lesion, ultrasound
19287 Device placement; first lesion, MR guidance
+19288 each additional lesion, MR

Notes:

- Imaging guidance is bundled with 19281-19288
- Use add-on codes for additional localization device placements with the same imaging modality.
- Use a primary code if an additional localization device placement is performed with a different imaging modality.

Category III Codes

There are two new codes for renal sympathetic denervation: 0338T (unilateral) and 0339T (bilateral). Radiofrequency energy is applied to the renal arteries to help control resistant hypertension.

Notes:

- S&I, including aortography and renal angiography, is bundled.
- Pressure gradients, if performed, are bundled.

There is also a new code, 0340T, for cryoablation of pulmonary tumor(s).

Notes:

- Code 0340T is unilateral.
- Imaging is bundled.
- The procedure includes extension of tumor to chest wall/pleura.

Incorporate Changes

New codes can be learned, but old habits die hard. When coding interventional radiology procedures performed in 2014, be ever vigilant of the new bundling concepts. HBM

David Dunn, MD, FACS, is vice president of ZHealth. He oversees physician coding, instructs ZHealth educational programs, and contributes to Dr. Z's Medical Coding Series. A graduate of Texas A&M University, Dunn completed his M.D. at the University of Texas, his surgical residency at Scott & White Hospital, and his vascular surgery fellowship at Baylor College of Medicine. A diplomat of the American Board of Surgery, Dunn is also certified in vascular surgery. He is a fellow of the American College of Surgeons and a member of the Southern Association for Vascular Surgery. Dunn is president of the AAPC National Advisory Board and a member of the Nashville, Tenn., local chapter.

GLOSSARY New IR CPT® Codes for 2014

10030 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

19081 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance

+19082 each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

19083 first lesion, including ultrasound guidance

+19084 each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

19085 first lesion, including magnetic resonance guidance

+19086 each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

19281 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance

+19282 each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)

19283 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance

+19284 each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

19285 first lesion, including ultrasound guidance

+19286 each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

19287 first lesion, including magnetic resonance guidance

+19288 each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

34812 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

34825 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel

+34826 each additional vessel (List separately in addition to code for primary procedure)

34841 Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

34842 including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery(s))

34843 including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery(s))

34844 including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery(s))

34845 Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

34846 including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery(s))

34847 including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery(s))

34848 including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery(s))

35475 Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel

36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

36216 initial second order thoracic or brachiocephalic branch, within a vascular family

37217 initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

37236 Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

+37237 each additional artery (List separately in addition to code for primary procedure)

37238 Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein

+37239 each additional vein (List separately in addition to code for primary procedure)

37241 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

37242 arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

37243 for tumors, organ ischemia, or infarction

37244 for arterial or venous hemorrhage or lymphatic extravasation

49405 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous

49406 peritoneal or retroperitoneal, percutaneous

49407 peritoneal or retroperitoneal, transvaginal or transrectal

61624 Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)

61626 non-central nervous system, head or neck (extracranial, brachiocephalic branch)

75894 Transcatheter therapy, embolization, any method, radiological supervision and interpretation

75898 Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis

75953 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation

75962 Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation

75989 Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation

76098 Radiological examination, surgical specimen

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

77012 Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation

77021 Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

0338T Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral

0339T bilateral

0340T Ablation, pulmonary tumor(s), including pleura or chest wall when involved by tumor extension, percutaneous, cryoablation, unilateral, includes imaging guidance

Modifier 59 Distinct procedural service

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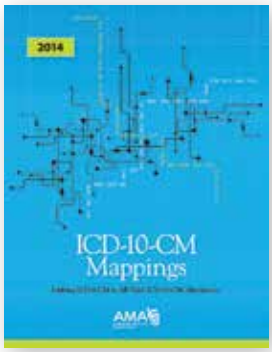

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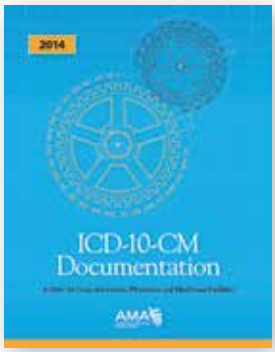

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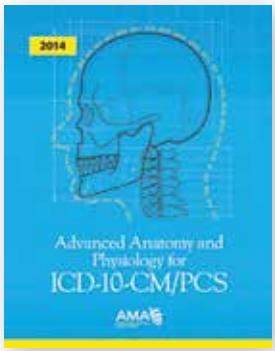

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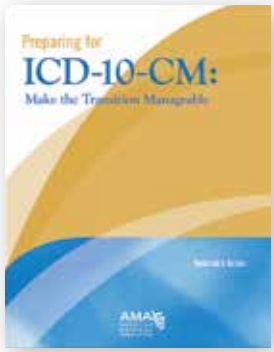

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By Brenda Chidester-Palmer, CPC, CPC-I, CASC, CEMC

Identify Signs and Symptoms of Allergic Reactions

Proper diagnostic coding requires knowing what to look for in documentation and patient history.

Allergic reactions are troublesome and not always easy to diagnose or code. For example, an allergic reaction might include nasal congestion and sneezing, rashes and itching, or all of the above. These symptoms can also be associated with the common cold, influenza, insect bites, or eczema. In ruling out these other known causes, a physician is able to diagnosis and treat the patient accordingly.

Allergy: Nasal Symptoms

When a patient presents with nasal symptoms, the provider generally begins the exam by taking a patient history. In reviewing the patient's history and current symptoms, the provider is able to determine whether the symptoms are short-lived or longstanding and possibly allergic reactions. If the provider believes the patient is experiencing an allergic reaction, a skin prick test may be ordered to determine what environmental factors or foods are causing the allergic reaction in the patient.

Some of the common allergens to test for are:

- **Legumes and nuts** – lima, soy, green beans, green peas, peanuts, and pecans
- **Cereal grains** – corn, oats, rye, rice, wheat, and barley
- **Milk** – cow's milk

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In reviewing the patient's history and current symptoms, the provider is able to determine whether the symptoms are short-lived or longstanding and possibly allergic reactions.

- **Egg** – egg white, egg yoke
- **Fowl** – chicken and turkey
- **Vegetables** – onion, garlic, green pepper, white potato, broccoli, carrot, squash, and tomato
- **Meats** – beef, pork
- **Fruits** – strawberry, banana, watermelon, cantaloupe, lemon, orange, peach, apple, and grapes
- **Miscellaneous** – yeast and chocolate
- **Fish and seafood** – tuna, salmon, catfish, trout, bass, perch, shrimp, crab, and lobster
- **Spices** – mustard, black pepper, and vanilla
- **Inhalant screening** – mold, trees 1 and 2, grass, fall pollen, mite (P and F), dog, and cat
- **Histamine positive control**

Only positive skin reactions are recorded. Positive reactions are typically scored with a "+," which indicates a slight or questionable reaction, to a "4+," which indicates a strong reaction. Additional testing may be performed based on results.

Diagnosis codes (as shown in **Table A**) are based on positive reactions, whether slight or strong.

When the allergens are identified, histamines and nasal sprays may be used for adequate control. The histamine positive control is important in testing because it tells the physician whether the patient's immune system will respond to histamines to help the body combat these irritants. Severe allergies, or those that cannot be adequately controlled with histamines, may require allergy injections to de-sensitize patients.

Histamine positive control is also important when a patient presents with allergy symptoms of nasal congestion, drainage, and sneezing, but reacts to none of the allergen skin tests. If the histamine control is positive, it validates the test results as negative. This usually, but not always, leads a physician to a diagnosis of vasomotor rhinitis (coding is shown in **Table B**).

Vasomotor rhinitis is a condition in which something that irritates the nose causes the symptoms (e.g., perfumes, scented candles, hair sprays, chemical fumes, household cleaning products, tobacco smoke, dust, molds, or air pollution). Symptoms may also be triggered by change in temperature or barometric pressure, alcohol ingestion, spicy foods, infections, or even emotions. Patients with vaso-

Table A: Diagnosis codes for allergic nasal symptoms

Allergy	ICD-9-CM	ICD-10-CM
Legumes and nuts	477.1 Allergic rhinitis due to food	J30.5 Allergic rhinitis due to food
Cereal grains	477.1	J30.5
Milk	477.1	J30.5
Egg	477.1	J30.5
Fowl	477.1	J30.5
Vegetables	477.1	J30.5
Meats	477.1	J30.5
Fruits	477.1	J30.5
Miscellaneous	477.1	J30.5
Fish and seafood	477.1	J30.5
Spices	477.1	J30.5
Inhalant screening (pollen, dog, cat, trees, mold)	477.0 Allergic rhinitis due to pollen 477.2 Allergic rhinitis due to animal (cat) (dog) hair and dander 477.8 Allergic rhinitis due to other allergen	J30.1 Allergic rhinitis due to pollen J30.81 Allergic rhinitis due to animal (cat) (dog) hair and dander J30.89 Other allergic rhinitis (applicable to perennial allergic rhinitis) J30.2 Other seasonal allergic rhinitis

Table B: Diagnosis when a histamine control is positive

Diagnosis	ICD-9-CM	ICD-10-CM
Vasomotor rhinitis	477.9 Allergic rhinitis, cause unspecified	J30.0 Vasomotor rhinitis

motor rhinitis are usually treated with nasal sprays, antihistamines, or leukotriene modifiers such as montelukast.

Allergy: Itching or Rash Symptoms

Itching and rash symptoms can be caused by so many things: Aside from an allergic reaction, itching and rash may be due to an insect bite, eczema or psoriasis, nerves, etc. A patient who presents with one or more of these symptoms may require multiple office visits before the physician can determine whether the patient is experiencing an allergic reaction, and if skin testing is merited.

Example

A woman begins scratching her stomach and legs. She makes an appointment to see her doctor. The physician reviews the history, along with current symptoms, and determines the rash is of unknown origin. He advises the patient to use anti-itching topical medication and to return if the problem persists.

Several weeks later, the patient returns with itching on her legs. In this patient's case, the history reveals the woman had been working in her yard. The physician determines that these are most likely chigger bites because itching and redness is confined to the lower legs.

Several weeks later, the woman again has itching on her abdomen and forearms, with raised areas. She returns to her physician. After obtaining a history, the physician determines this is probably dermatitis due to using a new detergent, and recommends she discontinue the product.

Two weeks later, the patient is back in the office with complaints of a rash and itching on her shoulders, forearms, stomach, and back of knees. The physician takes a history and determines that this is dermatitis due to the hydrochlorothiazide (HCTZ) the patient has been taking for her hypertension. The physician advises a change in medication. The patient agrees.

Four weeks later, the patient returns to her physician with complaints of an itchy rash, mainly on the arms, shoulders, and thighs. The patient has discontinued the HCTZ. The physician decides to send the patient to a dermatologist.

Table C: A patient may receive numerous diagnoses before specific allergens are detected.

Condition	ICD-9-CM	
Rash, unknown	782.1	Rash and other nonspecific skin eruption
Chigger bites	133.8	Other acariasis
Dermatitis due to detergent	692.0	Contact dermatitis and other eczema due to detergents
Dermatitis due to drug Hydrochlorothiazide	693.0	Dermatitis due to drugs and medicines taken internally
	E944.3	Saluretics causing adverse effects in therapeutic use
Hives, unspecified	708.9	Urticaria, unspecified
Allergic urticarial (hives)	708.0	Allergic urticaria
Allergy to shellfish/fish	477.1	
Allergy to cantaloupe/peach	477.1	
Allergy to trees 1 & 2	477.8	
Allergy to peanuts/pecans	477.1	

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Table D: Anaphylactic shock has its own set of codes.

Diagnosis	ICD-9-CM	ICD-10-CM
Anaphylactic reaction to:		
Unspecified food	995.60 Anaphylactic reaction due to unspecified food	T78.00 Anaphylactic reaction due to unspecified food
Peanuts	995.61 Anaphylactic reaction due to peanuts	T78.01 Anaphylactic reaction due to peanuts
Crustaceans	995.62 Anaphylactic reaction due to crustaceans	T78.02 Anaphylactic reaction due to shellfish (crustaceans)
Fruits and vegetables	995.63 Anaphylactic reaction due to fruits and vegetables	T78.04 Anaphylactic reaction due to fruits and vegetables
Tree nuts and seeds	995.64 Anaphylactic reaction due to tree nuts and seeds	T78.05 Anaphylactic reaction due to tree nuts and seeds
Fish	995.65 Anaphylactic reaction due to fish	T78.03 Anaphylactic reaction due to fish
Food additives	995.66 Anaphylactic reaction due to food additives	T78.06 Anaphylactic reaction due to food additives
Milk products	995.67 Anaphylactic reaction due to milk products	T78.07 Anaphylactic reaction due to milk and dairy products
Eggs	995.68 Anaphylactic reaction due to eggs	T78.08 Anaphylactic reaction due to eggs
Other specified food	995.69 Anaphylactic reaction due to other specified food	T78.09 Anaphylactic reaction due to other food products

Note: Codes T78.00–T78.09 require a 7th digit to form a valid code.

Anaphylactic shock is the most severe allergic reaction, and it has its own set of ICD-9-CM codes …

The patient presents to the dermatologist with active areas of redness and itching. The dermatologist determines the areas are hives, and ask about her allergies. The patient's only known allergies are to medications she is not currently taking. The dermatologist suggests allergy testing.

This patient has had numerous diagnosis codes on her way to being diagnosed with several allergies. From the first visit with symptoms to the final diagnosis, ICD-9-CM coding is shown in **Table C** (on the preceding page).

When testing was performed, the patient relayed she had been trimming trees and hauling tree branches, and eating a lot of the foods to which she is allergic. These allergies may have just cropped up, or she may have just increased her exposure to them. Obtaining a history and keeping records helped determine this patient's diagnosis of allergic hives.

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Allergic Reaction: Anaphylactic Shock

Anaphylactic shock is the most severe allergic reaction, and it has its own set of ICD-9-CM codes, shown in **Table D** (on the preceding page). Anaphylactic shock is an allergic reaction associated mainly with ingestion of foods. Allergy to peanuts or other nuts is probably the most common to produce anaphylactic shock. During anaphylactic shock, a person must seek immediate medical attention because swelling of the eyes, nose, tongue, and throat can inhibit breathing. Death is a likely result without medical attention.

As shown here, patient history and other documentation play crucial parts in both diagnosing and coding allergies. HBM

Brenda Chidester-Palmer, CPC, CPC-I, CEMC, CASCC, has 18 years of coding and billing experience. She is the principal of Palmer Coding Consultants and the former coding compliance manager for Kelsey-Seybold, a large group practice in Houston. Chidester-Palmer is an AAPC workshop presenter, past president of the Tyler, Texas, local chapter, and a former AAPC National Advisory Board member. She was a presenter at AAPC National Conferences in Long Beach, Calif., Jacksonville, Fla., and Las Vegas.

Compliance

By Susan Edwards, CPC, CEDC

Authenticate Services with Proper Physicians' Signatures

photo by iStockphoto © Ambientideas

Without a valid signature, you risk payer reimbursement.

The purpose of a physician's signature in a medical record or operative report is to clearly identify who ordered and provided supplies or services for the patient. It also serves as a testament that the services he or she provided were accurately and fully documented, reviewed, and authenticated. Equally important: Payers deny claims unsubstantiated by the service provider's signature. And not just any signature will do.

Acceptable Signatures

Each signature must be legible, and include the provider's first and last name. The signature also should include the provider's credentials (e.g., PA, MD, DO).

Medicare specifies acceptable methods of signing records/tests orders and findings, which include:

- **Handwritten** signatures or initials
- **Electronic** signatures usually contain date and timestamps and include printed statements, "electronically signed by" or "verified/reviewed by," followed by the practitioner's name and a professional designation.
- **Digital** signatures are an electronic method of a written signature typically generated by encrypted software, allowing sole usage.

Note: Electronic and digital signatures are not the same as "auto-authentication" or "auto-signature" systems, some of which do not mandate or permit the provider to review an entry before signing. Documentation that has been "signed, but not read" is not acceptable as part of the medical record.

Acceptable signature examples:

- Chart "accepted by" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed by" with provider's name
- "Signed before import by" with provider's name
- "Signed: John Smith, MD" with provider's name
- Digitalized signature: handwritten and scanned into the computer
- "This is an electronically verified report by John Smith, MD"
- "Authenticated by John Smith, MD"
- "Authorized by John Smith, MD"
- "Digital signature: John Smith, MD"
- "Confirmed by" with provider's name
- "Closed by" with provider's name
- "Finalized by" with provider's name
- "Electronically approved by" with provider's name

Unacceptable Signatures

Reports or records dictated and/or transcribed that do not include valid signatures finalizing and approving the documents are unacceptable and will not serve to support claims for reimbursement. At one time, signature stamps were permitted, but they are no longer recognized as valid authentication for Medicare signature purposes.

Unique Signature Situations

Sometimes the lines of acceptability aren't drawn quite as clearly.

Physician Left Practice

If a physician leaves a group practice before signing documentation for services he or she provided, another physician within the group may sign on his or her behalf; however, an explanation is required.

For example:

- The submitting provider, John Smith, MD, is unable to sign this medical record because he expired on 10/08/13; or
- John Smith, MD, relocated to Colorado on 10/08/13 and was unable to sign this medical record.

Incident-to

Incident-to a physician's professional services means the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Only the past, family, and social history and review of systems may be documented by ancillary personnel incident-to, and incorporated in to the evaluation and management (E/M) documentation, which must be reviewed and signed by the billing provider.

Electronic Health Records (EHRs)

EHR systems include a process that verifies that the individual signing his or her name has reviewed the contents of the entry, and has determined it contains the intended information.

Co-signatures

Early laws required all physician assistant (PA)-written chart entries to be signed by physicians, but this is no longer the case. PAs may now sign under their own national provider identifier (NPI) for services they provide. Co-signatures may continue to be used, however, to ensure a physician oversees the practice of a PA.

The American Medical Association (AMA) states physicians are ultimately responsible for coordinating and managing patient care and, with appropriate input of PAs, ensuring the quality of healthcare provided to patients. Whereas The Joint Commission recommends each accredited organization determine the necessity for co-signatures.

Be sure to annually review physician/PA team policies for your practice and update them as needed to reflect changes in healthcare regulations.

Signature stamps alone in medical records are no longer recognized as valid authentication for Medicare signature purposes, and may result in payment denials by Medicare.

Sloppy Signatures Call for a Signature Log

Providers will sometimes include a signature log in the documentation that identifies his or her initials, or an illegible signature, as the author of the documentation. The signature log might be included on the same page where the initials or illegible signature appear, or it might be a separate document. Reviewers will consider all submitted signature logs regardless of creation date.

A signature log should include the physician's printed name, full signature, and initials that appear on the document. The physicians can also list his or her credentials for further proof and validation.

Medicare transmittal 327 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R327PI.pdf) states that there are circumstances in which a provider does not need to sign an order for diagnostic testing. When the order is unsigned, the treating physician must include documentation, such as progress note indicating why he or she intended the diagnostic tests to be performed, and must authenticate this by a handwritten signature or e-signature.

Medicare does not require the ordering physician's signature on laboratory service requisitions. Although the physician's signature on a requisition is one way of documenting that he or she ordered the service, it's not the only permissible way of documenting it. For example, the physician may document in the medical record that he or she ordered specific services.

Keep an Eye on the Time

Providers should not add signatures to the medical record beyond the short delay that occurs during the transcription process, which is generally 24-72 hours. Instead, providers may employ the signature authentication process. Per Medicare guidelines, *Medicare Program Integrity Manual* (Pub 100-08):

> *Late signatures may not be added to the record, beyond the short delay that occurs during the transcription process. Medicare does not accept retroactive orders. If the provider's signature is missing from the medical record, submit an attestation statement from the author of the medical record.*
>
> *If the order is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests you ordered. A note stating "ordering lab" is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment.*

Signatures seem so insignificant in the grand scheme of things, but providers must be diligent and implement measures to ensure they are in compliance with signature guidelines. The consequences of non-compliance are grim. HBM

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By Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC, and G.J. Verhovshek, MA, CPC

Code Mohs in 6 Easy Steps

Look for location, stages, and tissue blocks in documentation.

When reporting Mohs surgery for treatment of skin cancer, documentation must confirm that a single provider acted as both the surgeon and pathologist. From there, you need only know the location of the treated lesion, plus the number of "stages" and required tissue blocks, to select an appropriate code.

Step 1: Confirm the Surgeon and Pathologist Are the Same

Mohs requires that a single physician act as both surgeon (excising tissue) and pathologist (immediately examining excised tissue to determine clear margins). Per CPT®, "if either of these responsibilities is delegated to another physician or qualified health care professional who reports the services separately, the … [Mohs] codes should not be reported."

Step 2: Identify Location

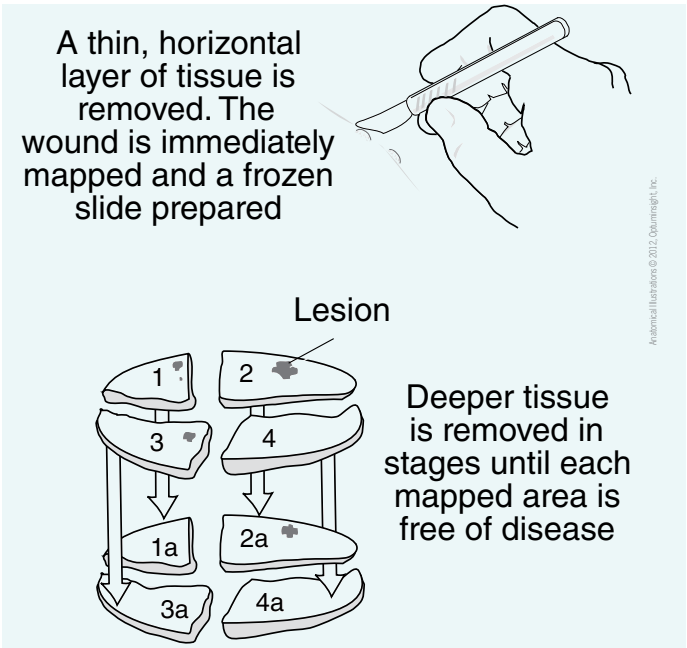
CPT® categorizes Mohs procedures by location:

- For lesions of the head, neck, hands, feet, and genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels, look to code 17311 and add-on code 17312.
- For lesions of the trunk, arms, and legs, select code 17313 and add-on code 17314.

Regardless of location, you might also need to report add-on code 17315, as explained in the **Mohs Code Definitions** sidebar.

Step 3: How Many Stages? How Many Blocks?

Things become more complicated at this step. It helps greatly if you understand what the surgeon/pathologist does in the procedure room.



To spare as much healthy tissue as possible (while still eradicating cancerous cells), the physician removes tissue in *stages*. The first stage is to excise the lesion. The specimen is divided into smaller portions, called *blocks*.

Per CPT®, "a tissue block … is defined as an individual tissue piece embedded in a mounting medium for sectioning." The location of each block within the stage is carefully mapped, and each block is examined for cancer cells.

Where the surgeon sees a clear margin (no malignant tissue), no further excision is necessary beyond that block. Where the physician finds malignancy, a further stage is required to remove additional material (this is the second stage, which is again divided into blocks). The process continues until no further cancer cells are identified.

Bottom line: Each time the surgeon excises material counts as a stage. Each slide resulting from an individual stage counts as a block.

Step 4: Separately Consider Each Lesion Treated

If the surgeon/pathologist uses the Mohs technique on multiple lesions during the same session, code for each lesion separately.

Step 5: Put It All Together

Using steps 1-4, test your skills with these coding scenarios.

Scenario 1: The patient presents with a basal cell carcinoma of the central portion of the forehead. After prepping the patient and site, the physician removes the carcinoma (first stage) and divides it into four tissue blocks for examination. Upon microscopic examination, the physician finds the margins are clear of carcinoma.

The appropriate coding would be:

CPT®: 17311

ICD-9-CM: 173.31 *Basal cell carcinoma of skin of other and unspecified parts of face*

Scenario 2: The patient presents with a squamous cell carcinoma of the nose. After prepping the patient and site, the physician removes the carcinoma (first stage) and divides the stages into six tissue blocks for examination. Upon microscopic examination, the physician finds there are positive margins. He removes the positive margin with another excision (second stage), which is divided into three tissue blocks for examination. Upon microscopic examination, the physician finds the margins are negative.

The appropriate coding would be:

CPT®: 17311 (first stage)
+17312 (second stage)
+17315 (six blocks)

ICD-9-CM: 173.32 *Squamous cell carcinoma of skin of other and unspecified parts of face*

Scenario 3: The patient presents with three skin cancers: basal cell carcinoma of the right neck, squamous cell carcinoma of the right hand, and squamous cell carcinoma of the left ala. After prepping the patient and the sites, the physician first removes the BCC of the neck. He divides it into two tissue blocks. Under microscopic examination, the margins are negative. Next, the physician removes the SCC of the hand, dividing that stage into three tissue blocks. Under microscopic examination, the margins are negative. Lastly, the physician removes the SCC of the left ala, dividing the stage into six blocks. Under microscopic examination, there is a positive margin. The physician then takes a second stage, which is divided into two blocks. Under microscopic examination the margins are negative.

The appropriate coding in this scenario is:

Each time the surgeon excises material counts as a stage. Each slide resulting from an individual stage counts as a block.

CPT®:

- 17311 (neck)
- 17311-59 *Distinct procedural service* (hand)
- 17311-59 (nose)
- 17312 (second stage of nose)
- 17315 (extra block of first stage of nose)

ICD-9-CM:

- 173.41 *Basal cell carcinoma of scalp and skin of neck*
- 173.62 *Squamous cell carcinoma of skin of upper limb, including shoulder*
- 173.32 (nose)

Tip: Refer to the ICD-9-CM neoplasm table for the most appropriate diagnosis for the patient's skin cancer.

Step 6: Be on the Lookout for Separate Procedures

The physician may need to conduct additional procedures during the same encounter as a Mohs procedure. Depending on the procedure and the circumstances, you may be able to separately report additional work.

Biopsy and Histopathologic Exam

Because histopathologic examination is included in the Mohs procedure, you may not separately report pathology codes 88302-88309. Likewise, you would not typically report biopsy separately with a Mohs procedure.

The exception to this rule occurs when there is "no prior pathology confirmation of a diagnosis," according to CPT®. In such a case, the same-day biopsy (11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion*, +11101 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)*), and frozen section pathology (88331 *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen*) may be reported separately, in addition to the Mohs surgery. You must append modifier 59 *Distinct procedural service* to the biopsy and pathology codes to confirm these procedures are not a routine part of the Mohs procedure.

For example, a new or established patient is seen in clinic for a routine skin check. During the examination, the provider identifies a suspicious lesion of the left cheek. After discussion with the patient on treatment options, the patient consents to a biopsy of the lesion. The area is prepped and draped in a sterile fashion, with the use of a 3 mm punch tool. The provider takes a biopsy of the lesion. The specimen is then prepared for frozen section, and is found to be positive for BCC. With the patient's permission, the physician performs a single stage Mohs in removing the carcinoma.

In this example, the proper reporting would be:

CPT®:

- 17311 (for the Mohs surgery of the cheek)
- 11100-59 (for the biopsy)
- 88331-59 (for the frozen section of the biopsy)

Stains

Mohs surgery includes "routine stains," such as hematoxylin and eosin (H&E) or toluidine blue. If the physician performs an additional, atypical stain, you may report the appropriate special stain code. CPT® instructs, "When a nonroutine histochemical stain on frozen

More on Mohs

Mohs micrographic surgery is named after Frederic E. Mohs, MD, (1910-2002) who, as a 28-year-old medical student, developed the technique to treat malignant skin lesions, nearly 75 years ago. During Mohs surgery, the surgeon removes the lesion in small sections, examining each section in the procedure room to determine where further excision is required to eliminate all cancerous cells. The procedure usually takes place in an outpatient setting, and typically involves several stages.

The Skin Cancer Foundation reports:

> *Today, Mohs surgery has come to be accepted as the single most effective technique for removing Basal Cell Carcinoma and Squamous Cell Carcinoma (BCCs and SCCs), the two most common skin cancers. It accomplishes the nifty trick of sparing the greatest amount of healthy tissue while also most completely expunging cancer cells; cure rates for BCC and SCC are an unparalleled 98 percent or higher with Mohs, significantly better than the rates for standard excision or any other accepted method.*

Source: **www.skincancer.org/skin-cancer-information/mohs-surgery**

Mohs Code Definitions

17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head neck, hands, feet, genitalia or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves or vessels; first stage, up to 5 tissue blocks

+17312 each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)

Report 17312 only with 17311.

17313 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms or legs; first stage, up to 5 tissue blocks

+17314 each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)

Report 17314 only with 17313.

Codes 17311-17314 define "up to five tissue blocks." If a single stage must be divided into more than five blocks, you may report an add-on code for each additional block beyond the initial five.

+17315 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure)

You may report 17315 with all codes 17311-17314, when appropriate.

tissue is utilized, report +88314 [Special stains (List separately in addition to code for primary service); histochemical staining with frozen section(s)] with modifier 59."

Repair of Surgical Wounds

CPT® instructs, "If a repair is performed, use separate repair, flap, or graft codes."

For example, in scenario 3, the surgeon/pathologist closes the surgical wound using a cheek rotation flap measuring 5.2 cm2. In this case, correct coding would allow you to separately report 14040 *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less*. Because treatment is directed at the suspicious lesion, which was proven to be carcinoma, your diagnosis for the entire encounter would be 173.31. HBM

Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC, is coding and billing manager for Travis C. Holcombe, MD. She has over 20 years of coding and billing experience, is an AAPC workshop presenter and AAPC ICD-10 expert trainer, and served on the 2007-2009 National Advisory Board. Ward was the 2012 president of the Glendale, Ariz., local chapter, and has held offices with the Phoenix, Ariz., local chapter. She is a member of the 2013-2014 AAPC Chapter Association board of directors, region 8-West.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Fort Myers, Fla., local chapter.

Why I Code

Julia K. Merritt, M Ed, RT, CPC, RCC

I never considered coding as a career option. I couldn't have been more surprised by the positive turn my life took when I began training for a job in medical coding at Thomas Jefferson University Hospital, Philadelphia.

Having a background in radiology technology afforded me a solid understanding of anatomy, physiology, and medical terminology. I bought the Radiology Certified Coding (RCC) exam book, and passed the exam on the first try.

To learn more about medical coding, I attended a medical coding course at Montgomery County Community College in Blue Bell, Pa. My teacher asked me to assist with presenting the Radiology CPT® 70000 series. I jumped out of my seat and ran to the front of the class, excited to share advancements in radiology procedures.

I passed the Certified Professional Coder (CPC®) exam on the second try. I cannot preach enough about time management when taking the exam.

Credentials Open Doors

Armed with new credentials, I sent my resume to Montgomery County Community College Work Development division for the Blue Bell and Pottstown campus and was offered a part-time position teaching the same course. Taking this course and passing the CPC® exam allowed me to share with my students, and soon-to-be colleagues, what is necessary to become a skilled CPC®. I know it will have a long reaching effect on their lives.

I couldn't have been more surprised by the positive turn my life took when I began training for a job in medical coding …

The Place to Be

Discovering new skills within has stretched my journey from radiologic technologist to neuroradiology technologist, to patient registrar, to ultrasound scheduler, to patient account representative, and now to senior radiology coder and college faculty. Whether I am scheduling webinars for employees, tutoring students, interpreting procedure notes to accurately assign codes, attending compliance and chapter meetings, or answering a call from a human resources representative to give a reference for a job applicant, this is where I want to be.

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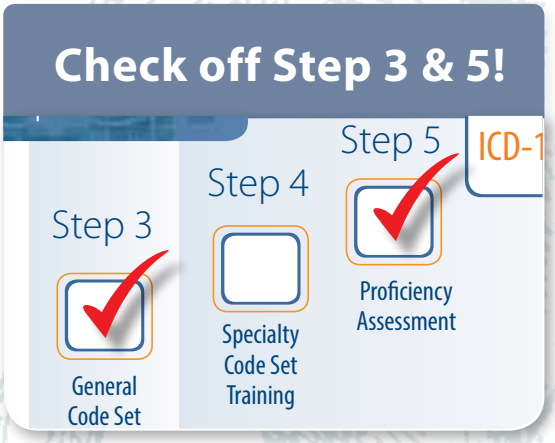
- Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, CPEDC, CENTC
  Vice President, ICD-10 Training and Education



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NOTE:

Local Chapter: Only available with participating chapters. Registration available through local chapter.

Onsite: Only available for groups of 10 or more.

Local Chapter and Onsite training include the option to add-on AAPC's online ICD-10-CM proficiency assessment course at a reduced cost. Successful completion of the hands-on exercises and questions found at the end of the course will satisfy AAPC's certification maintenance requirements for ICD-10-CM.

By Kenneth D. Beckman, MD, MBA, CPC, CPC-P, CPC-H

Cover

CPT® and Affordable Care Act Create Payer Conundrum

When it comes to meeting "first dollar coverage" requirements using CPT®, the two are at odds.

The Affordable Care Act (ACA), or Obamacare, includes a list of services that payers are required to cover without a deductible or co-pay—what is commonly referred to as "first dollar coverage." These services include preventive care for adults and children, as well as prenatal (antepartum) care for pregnant women.

These codes have worked well for many years, but do create a conundrum in coding under the ACA. Let's take a look at the difficulty payers face when following the ACA first dollar coverage requirement using current CPT® coding.

Author's note: This article has no political intent, and is neither an endorsement nor a criticism of the ACA. Likewise, the article is not a critique of the American Medical Association's CPT® codebook.

Maternity Care

Under the ACA, prenatal care is a first dollar benefit. It's not yet clear what, specifically, is included under prenatal care. But it's certain that the routine services of the obstetrician, family physician, midwife, or other provider are subject to this requirement. For the sake of brevity, let's use the term obstetrician to include all healthcare professionals providing routine prenatal services.

For many years, obstetricians have billed for maternity services using the global obstetrical codes:

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care

59510 Routine obstetric care including antepartum care, cesarean delivery and postpartum care

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery

59618 Routine obstetric care including antepartum care, cesarean delivery and postpartum care, following attempted vaginal delivery after previous cesarean delivery

These codes now create a problem for payers. Under ACA, payers are required to pay part of the global service as first dollar coverage, while the remainder of the service is subject to policy deductible and co-payment. This leaves payers with two options, neither of which is appealing:

1. The payer can re-code the global service into antepartum and delivery/postpartum codes.

   For instance, 59400 (global vaginal delivery) can be split into

Under the ACA, prenatal care is a first dollar benefit. It's not yet clear what, specifically, is included under prenatal care.

59426 *Antepartum care only, 7 or more visits* and 59410 *Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care*. If the payer has an agreed fee schedule with the provider, and the sum of these two codes equals the fee schedule for the global code, this option can work. Although, it likely will require manual adjudication, resulting in payment delay and increased administration costs.

2. The payer can opt to pay a percentage of the global fee as first dollar, with the remainder subject to policy provisions.

   One large national provider recently announced that it will use this option. But because the decision for cesarean section typically does not affect the antepartum care, and the fee schedule for global maternity care varies by the four aforementioned global codes, a fixed percentage payment for antepartum care will also vary. Depending on the chosen percentage, this may result in over or under valuation of the antenatal care services.

There is also a third option:

3. The obstetrician could submit all claims for global maternity care, splitting the services into the antenatal portion (59425 *Antepartum care only; 4-6 visits*, 59426) and the delivery portion (59410, 59514 *Cesarean delivery only*, 59614 *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care*, 59622 *Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care*).

   Although this may seem like a logical solution, most payers have claims software that considers this unbundling, and will re-bundle the two claim lines into the global service code. To make matters more complicated, some payers may request this split, and others will want the claim bundled to pay a percentage of the total.

OB Panel

In addition to the global maternity care codes, obstetricians routinely order an obstetric panel (80055 *Obstetric panel*) as part of the first obstetrical visit screening. This panel, by CPT® definition, must include:

- Complete blood count (several potential codes)

- Hepatitis B surface antigen (HBsAg) (87340)
- Antibody, rubella (86762)
- Syphilis test (86592)
- Antibody screen, RBC (86850)
- Blood typing, ABO (86900)
- Blood typing, Rh (D) (86901)

The ACA spells out that some of these components fall under the United States Preventive Services Task Force (USPSTF) (A) or (B) recommendations requiring first dollar coverage. Specifically, the USPSTF recommends:

- Routine screening for iron deficiency anemia in asymptomatic pregnant women (B)
- Screening for hepatitis B virus infection in pregnant women at their first prenatal visit (A)
- Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care (A)
- Screening for all pregnant women for syphilis infection (B)

Although the ACA also requires first dollar coverage of prenatal services, it does not spell out the specifics (other than in reference to the USPSTF recommendations). We don't know if the intent was to cov-

er the other components of an obstetrical profile at first dollar.

The ACA also requires first dollar coverage of other maternity tests, as spelled out in the USPSTF recommendations, but these are not included in panels (and are outside of the scope of this article). These include screening:

- For asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later (B)
- For chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk (B)
- All sexually active women, including pregnant women, for gonorrhea infection if they are at increased risk (i.e., young women or those who have other individual or population risk factors) (B)
- All pregnant women for human immunodeficiency virus (HIV), including women in labor who are untested and whose HIV status is unknown (A)

Other USPSTF recommendations not specific to pregnant women may still apply based on age, gender, and risk.

Other Lab Panels

The CPT® codebook lists a number of lab panels that include one or more components of USPSTF recommendations. Like the global obstetrical care codes, this also creates a conundrum for payers. In most cases, the relative value of the USPSTF recommendation that requires first dollar coverage is a small fraction of the relative value of the overall panel. This allows the payer to choose options similar to those outlined under global maternity care:

1. Pay for only the relative value of the USPSTF recommended component at first dollar, and subject the remainder of the panel to contract provisions.
2. Pay for the entire panel at first dollar coverage.

There are some inherent difficulties in the first option. Although global obstetrical care can be split into only two components, the panels may include up to 17 components. According to CPT® rules, all components must be performed to use the panel code.

For instance, if the provider bills 80050 *General health panel* using a screening diagnosis code, USPSTF recommendations require the payer to cover the glucose (82947 *Glucose; quantitative, blood (except reagent strip)*) component of the comprehensive metabolic panel at first dollar, but leaves the remainder of the panel subject to contract provisions. This is based on the USPSTF recommendation, "The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. (B)"

Other panels that include glucose (82947) are:

80047 Basic metabolic panel (Calcium, ionized)

80048 Basic metabolic panel (Calcium, total)

80053 Comprehensive metabolic panel

80069 Renal function panel

Lipid Panel

Code 80061 *Lipid panel* includes:

82465 Cholesterol, serum or whole blood, total

83718 Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)

84478 Triglycerides

The USPSTF includes the following lipid screening recommendations:

- Screening men age 35 years and older for lipid disorders (A)
- Screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease (B)
- Screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease (A)
- Screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease (B)

This appears to require first dollar coverage (based on age and gender) of the lipid panel. The clinical considerations section of the USPSTF recommendations states, however, "The preferred screening tests for dyslipidemia are total cholesterol and HDL-C on nonfasting or fasting samples. There is insufficient evidence of the benefit of including TG (triglycerides) as a part of the initial tests used to screen routinely for dyslipidemia." This means you could make the

Although global obstetrical care can be split into only two components, the panels may include up to 17 components.

Until, if ever, such a code restructuring takes place, payers are forced to find innovative methods for handling these codes.

argument that only the total cholesterol and HDL portions of the lipid panel are subject to first dollar coverage, and the triglycerides are subject to contract provisions.

Acute Hepatitis Panel

Code 80074 *Acute hepatitis panel* includes:

86709 Hepatitis A antibody (HAAb); IgM antibody

86705 Hepatitis B core antibody (HBcAb); IgM antibody

87340 Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)

86803 Hepatitis C antibody

The USPSTF recommends screening for hepatitis C virus (HCV) infection in patients at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965 (the USPSTF hepatitis B recommendation is included under the aforementioned maternity discussion).

Based on this recommendation, only the hepatitis C antibody portion of the acute hepatitis C panel would be covered at first dollar. This panel creates an additional twist because it's named an "acute" panel; and, based on the included components, one could argue that this panel is not for screening. Therefore, the one component included in the USPSTF recommendation is not being performed for screening and, as such, is not subject to first dollar coverage.

Colonoscopy

The final area to look at is the screening colonoscopy. The AMA added modifier 33 *Preventive service* to allow providers to document that—despite the findings at the time of the procedure—the colonoscopy was performed for screening purposes. CPT®, however, does not offer an easy method to distinguish screening from diagnostic.

This would be easier to code and to process claims if the coding were changed to an "add-on" status, where the base code was the colonoscopy (45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)*) and the add-on codes were the procedures. This could be accomplished by adding a semi-colon after the description of colonoscopy (45378) and changing procedure codes 45379-45392 to add-on codes. These codes could then be revalued to reflect only the additional work for each procedure over and above that which is required to perform a screening colonoscopy.

Until, if ever, such a code restructuring takes place, payers are forced to find innovative methods for handling these codes. For example:

1. Pay the first colonoscopy procedure code as first dollar preventive care, and pay any additional colonoscopy procedure codes—subject to contract provisions—at whatever reduced secondary procedure payment scheme the provider chooses.

2. Pay only the portion of the first colonoscopy code equal to the payment for a screening colonoscopy without a procedure (45378); pay the remainder of the first procedure code as an initial procedure; and pay any additional colonoscopy procedure codes subject to contract provisions at whatever reduced secondary procedure payment scheme the provider chooses.

Some payers use a hybrid of the second option. Rather than use the standard 50 percent reduction to the second surgical procedure claim, they pay only the portion of the second procedure code that exceeds the value of the base colonoscopy.

The bottom line: Payers and providers must agree to and observe workarounds that allow for proper reporting and reimbursement of many services requiring first dollar coverage under the ACA. HBM

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By Jim Strafford, CEDC, MCS-P

Photo by iStockphoto/Pgiulicha

Facility

2014 OPPS Collapses Clinic Visit E/M Levels for G0463

Recognize the impact of "one clinic code fits all" on hospital reimbursement and your coding process.

Effective Jan. 1, 2014, hospitals are required to report outpatient clinic visits furnished to Medicare patients using a single, new HCPCS Level II code, G0463 *Hospital outpatient clinic visit for assessment and management of a patient*, rather than CPT® evaluation and management (E/M) codes 99201-99205 (new patient) and 99211-99215 (established patient). Let's explore how this reduction to a single code might affect reimbursement and coding for your facility.

Note: This particular regulation affects only facility-side clinic services, not physician services or the professional component of services provided in the hospital clinic.

Reimbursement for G0463

Payment for G0463 under the 2014 Outpatient Prospective Payment System (OPPS) is $92.53 and, according to the Centers for Medicare & Medicaid Services (CMS), is revenue neutral because it is based on "average reimbursement" to hospitals for all outpatient levels. That's not exactly correct. A hospital's 2014 revenue generated from G0463 will depend on its clinic acuity mix and the average E/M levels it reported prior to Jan. 1.

A hospital's average Medicare payment for outpatient clinic visits depends heavily on its outpatient acuity mix. Clinics with an older, sicker patient population generally experience higher acuity levels. Coding guidelines a facility follows also play a role; hospitals have no equivalent of the *1995* or *1997 Documentation Guidelines for Evaluation and Management Services* to standardize coding for E/M services. Many hospitals code based on CPT® guidelines, with hospital clinic time and cost factored in.

One aspect of CPT® guidelines recognized by CMS and used by hospitals is the distinction between new and established patients. Hospital clinics are not required to follow these guidelines, but from a reporting and census view, tracking new vs. established outpatients is appropriate.

For hospital outpatient/clinic visits for services *prior to* Jan. 1, 2014 codes 99201-99205 and 99211-99215 translated to

At first glance, it appears Medicare has greatly simplified outpatient coding. "One code fits all" should result in greater coder productivity. It should be audit proof, too.

five distinct ambulatory payment classifications (APCs) for outpatient reimbursement. **Chart A** illustrates the payment affect of G0463 on reimbursement.

If your hospital has not done so already, it should calculate its average Medicare payments for the 10 E/M outpatient clinic visit codes that are no longer accepted by Medicare (99201-99205 and 99211-99215). If the hospital's average payment was greater than $92.53, the impact of G0463 will be a decrease in Medicare outpatient revenue. If the hospital was averaging less than $92.53 per Medicare outpatient visit, the revenue impact should be positive.

Level Ground

The elimination of "levels" is perhaps part of a trend toward code bundling that has been going on for many years, as well as a move to reduce government spending. There is *no difference* between new and established patient visits reported using G0463.

For hospitals that reported mostly lower level new (99201-99202) and established (99211-99213) CPT® codes, G0463 represents a reimbursement increase, ranging from $18.85 to $35.76 per visit. For hospitals that reported mostly higher level new (99203-99205) and established (99214-99215) CPT® codes, G0463 means a reimbursement decrease, ranging from $4.46 to $83.26 per visit.

Higher level, new patient CPT® codes (99203-99205) are more highly valued than the corresponding established patient codes (99213-99215). Prior to Jan. 1, the five APCs for clinic services (0604-0608) were applied differently to new vs. established patients. For example, new patient code 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* merited the highest reimbursement (APC 0608, $175.79), while the highest-level established patient code (99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity*) correlated to APC 0607, which reimbursed only $128.78.

Analysis:

- Hospital clinics that previously reported mainly 99201-99212 and/or 99211-99213 (e.g., low-level services) for Medicare clinic visits should see a revenue gain from G0463. This scenario is unlikely because Medicare typically serves an older, sicker population with the expectation of higher acuity visits.
- Hospital clinics with higher acuities (e.g., more high-level E/M clinic visits) will likely see a revenue decrease.
- Hospital with a higher proportion of new patients vs. established patients will also likely see a revenue decrease.

Coding Conundrum

At first glance, it appears Medicare has greatly simplified outpatient coding. "One code fits all" should result in greater coder productivity. It should be audit proof, too. In fact, CMS cited administrative and coding simplification as justification for the new code. But hospital outpatient coders most likely will (and should) continue to code all 10 outpatient E/M levels, for all payers, for a number of reasons:

- Hospitals will still want to track outpatient acuity levels for all payers. Calculating a single service level for Medicare will compromise critical metrics related to outpatient acuities at the facility, diagnoses that typically correspond to each level, treatment and medications by level, etc.
- For similar reasons, hospitals will also want to continue tracking new vs. established clinic visits, as well as demographic changes and clinic growth, which will require hospitals to identify new vs. established patients.

Although coders may continue to assign CPT® codes

There is *no difference* between new and established patient visits reported using G0463.

Table A: Impact of G0463 for Clinic Visits

	Through 12/31/13			As of 1/1/14			
	CPT®	APC	Payment	HCPCS	APC	Payment	Payment Variance in $ (2013 vs 2014)
Clinic Visit New Patient	99201	604	$56.77	G0463	634	$92.53	35.76
	99202	605	$73.68	G0463	634	$92.53	18.85
	99203	606	$96.99	G0463	634	$92.53	-4.46
	99204	607	$128.48	G0463	634	$92.53	-35.95
	99205	608	$175.79	G0463	634	$92.53	-83.26
Established Patient	99211	604	$56.77	G0463	634	$92.53	35.76
	99212	605	$73.68	G0463	634	$92.53	18.85
	99213	605	$73.68	G0463	634	$92.53	18.85
	99214	606	$96.99	G0463	634	$92.53	-4.46
	99215	607	$128.78	G0463	634	$92.53	-36.25

99201-99205 and 99211-99215 for all outpatient clinic visits, the hospital billing system will be set up to convert all 10 outpatient levels to G0463 for Medicare patients. G0463 most likely will not—and should not—affect your coding process. A "one code fits all" philosophy is most likely not a path to staff reduction. If your hospital has moved to coding G0463 only, without conversion to levels for reporting purposes, you might take the issue up with your management, for all of the reasons listed above.

Other Payers, Services, May Adopt "One Code" Approach

A "one code fits all" approach will simplify the claims process for Medicare payers, who now can reduce their payment codes and, hopefully, their rejection and denial codes. Other payers may try to follow CMS' lead. Your hospital managed care personnel should review the language of your current contracts. If CPT® codes are clearly spelled out with fees, you could have an argument against changes in payment methodology. Note, however, that many managed care contracts include clauses that allow the payer to "follow government changes."

Emergency department (ED) services have avoided the "one code" fate; however, CMS has said that it "intends to further explore the cost issues related to facility billing for ED visits." It seems that the ED facility levels have received a temporary reprieve—*not* a pardon. CMS has accepted the argument that one-level ED coding would punish high acuity, inner city trauma centers. CMS may seek to overcome this objection by designating one ED HCPCS Level II for designated high acuity hospitals and teaching facilities in the inner city, and a second (lower valued) ED service HCPCS Level II code for facilities not meeting those criteria. For this reason, groups lobbying CMS for retention of the five ED levels found in CPT® should likewise continue to lobby for (and offer) uniform documentation and coding guidelines for the ED. HBM

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By Betty Hovey, CPC, CPC-H, CPB, CPMA, CPC-I, CPCD

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

What are the four valves of the human heart?

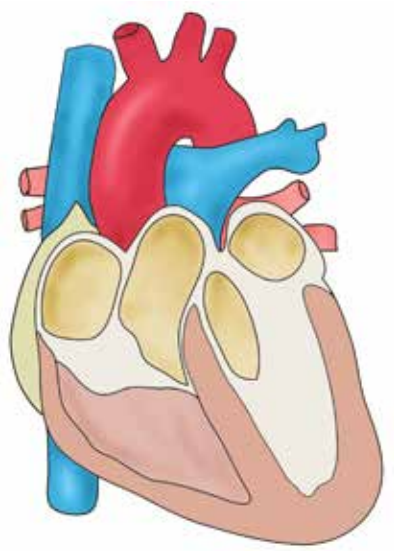
a. Semilunar, mitral, ventricular, tricuspid

b. Aortic, mitral, atrial, tricuspid

c. Aortic, tricuspid, pulmonary, chordae

d. Tricuspid, mitral, pulmonary, aortic

Check your answer on page 65.



Due to the clinical nature of ICD-10-CM—the diagnosis code set the healthcare industry will begin using Oct. 1, 2014—a strong understanding of anatomy and physiology (A&P) will be required for accurate reporting of patients' medical conditions.

Take this monthly quiz, in addition to AAPC's ICD-10 Anatomy and Pathophysiology advanced training, to prepare for the increased clinical specificity requirements of ICD-10-CM. To learn more about AAPC's ICD-10 training, go to www.aapc.com to download AAPC's ICD-10 Service Offering Summary.

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By Dennis P.H. Mihale, MD, MBA; Sidney Summers Welch, JD, MPH; and Jeremy P. Burnette, JD, MA

Respond to a Payer Audit

Not so fast!

Part 3: Learn how to appeal appropriately.

Being audited is serious business. If you think there is an error with the payer's findings, you have a right to appeal the decision and should do so, as appropriate. But you'll need to have a firm grasp on the issues involved and act accordingly. In some cases, a settlement may be the better option. Let's look at the appeal process and your options for appropriate recourse.

Editor's Note: This is the last in a series of articles providing you with advice on how to handle payer audits, minimize exposure, and limit future audits. Part 1 (January, pages 54-56), and Part 2 (February, pages 48-53) of this series explored how to respond to private and government payer audits. In this final installment, we discuss the appeals process.

To Appeal or Not: That's the Question

Following an audit, the payer will send the provider a notification of its findings. The notification will include a request for repayment if the audit shows overpayment on behalf of the payer. When deciding whether to appeal a demand for repayment, be aware of appeal deadlines and what you must do to preserve your rights. Decisions regarding whether to appeal a repayment demand are often made on a cost-benefit analysis, and are evaluated against this framework throughout the process.

An appropriate first step may be to call the payer's medical director. This strategy is a good option if:

- You are certain the payer has made an error that requires a level of understanding beyond that of a payer representative;
- Payer representatives are being uncooperative; or
- The subject of the audit is clinical in nature and requires clinical input.

If you pursue this option, you must have a firm understanding of the issues involved. Conversations with the medical director are not privileged and could be subject to discovery or testimony in a proceeding. Confirm any information from the director with a follow-up email to create a record of the conversation, and save this email in the case file.

Consider filing an appeal if:

- The issue is not resolved by conversation with the payer's medical director;
- Repayment would set a dangerous precedent for future payment disputes; or
- The demanded repayment amount is significantly inaccurate.

When deciding whether to appeal a demand for repayment, be aware of appeal deadlines and what you must do to preserve your rights.

Gather the Facts

If the alleged overpayment is the result of a coding issue, first review the claims in question with a Certified Professional Coder (CPC®). A physician with extensive experience in coding matters also may be particularly persuasive. Such an expert should be retained through the provider's attorney, who should manage the review to preserve the confidentiality of the findings under applicable privilege. The provider should give the coding expert all of the information and correspondence that has been gathered regarding the payment issue. This will enable the expert to evaluate the merits of the repayment demand. Based on the expert's review, an appeal may be warranted.

If clinical issues are the basis of an overpayment claim, clinical literature (particularly authoritative, justifying the implementation and reimbursement of a particular medical treatment) authored by a reputable third party may further support your position. Collect and evaluate this literature, in addition to the expert's support and your provider's documentation, before appealing a payment decision based on a clinical determination.

Throughout the appeal process, focus on clinical authority and the payer's own guidelines rather than unsupported arguments of "fairness."

Appealing Private Payer Decisions

For private payers, your contracts (or ancillary policies and procedures) will specify your appeal rights and processes. Review your provider agreement and related policies and procedures carefully—both before signing contracts and when faced with a repayment demand. If you do not have a copy of the payer's appeals process, request one in writing. All plans are different, and the appeal process will vary among payers.

Generally, the appeal process will have three levels: informal complaint, formal appeal, and filing a grievance.

Informal Complaint

Many provider agreements allow the provider to file a complaint about how the payer has processed a claim. Typically, the initial complaint process is relatively informal and requires a written complaint to the carrier's customer service department. Some carriers permit complaints to be conducted telephonically. This process can end a payment dispute quickly and easily when it's based on something simple (e.g., a clerical error or when the payer lacks sufficient records to make an informed payment decision).

Take contemporaneous notes of all your conversations with the payer, keep copies of all correspondence, and confirm the resolution in writing. Document that, although the matter is resolved, you do not waive your rights to challenge the payer if, despite the assurances you have received, the payer attempts to reopen the matter. Also make sure the person responding to your appeal has authority to resolve the matter from the payer's perspective.

Again, be mindful of time deadlines for informal resolution. You always want to preserve as much time as possible for a formal appeals process, if necessary.

Formal Appeal

Provider agreements (or the ancillary documents) outline the formal processes to appeal payers' payment decisions. You must review your agreement (or ancillary documents) with the specific payer to comply with the rules of the appeal process. Failure to do so may result in a failed appeal simply because you didn't meet deadlines, follow outlined procedures, or provide necessary information.

For example, the payer may set a time limit for when a provider may appeal a payment decision. These time limits may range from 60-180 days, or more. State law may set certain time limits for such appeals, as well. You'll need to reconcile the two sets of deadlines.

Most plans provide for multiple levels of administrative appeal. The initial appeal is likely to be reviewed by an individual who did not work on the original payment decision. If the underlying dispute is a utilization review question, request for a physician in the same medical specialty to review the payment decision. If the payer does not have such a physician on staff, you may request an independent external review to gain that expertise.

If you are not satisfied with the results of the initial appeal level, you can typically file a higher-level appeal. Again, follow the procedures outlined in the provider agreement (or ancillary documents) closely. An elevated appeal usually provides a hearing for you to present evidence or explain your position more fully. A panel (rather than an individual) typically reviews the payment decision.

Grievance

If you're still not satisfied with the payment decision, you may be able to file a formal grievance with the insurance carrier. The payer will investigate the grievance confidentially and issue an opinion within the time specified in the provider agreement or ancillary documents.

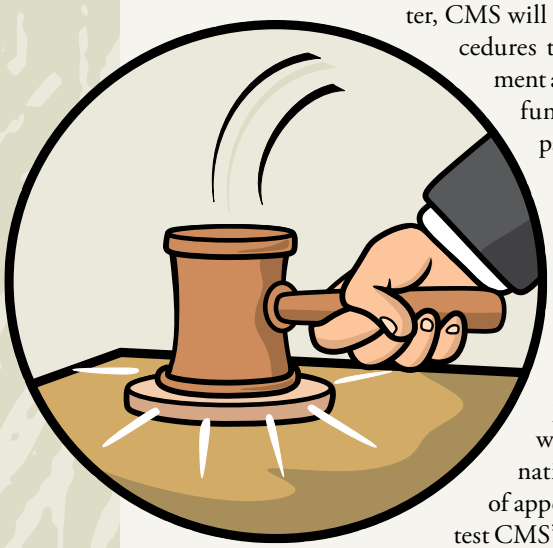
The formal grievance is often the final step in the internal, adminis-

trative review process. If you remain unsatisfied after exhausting the appeals and grievance procedures, you may be able to turn to your state insurance commissioner or court system for resolution. Often, however, payer contracts require such disputes to be resolved by binding arbitration. Know what your contract requires and be prepared to negotiate these provisions, depending on the payer's history and reputation in your state.

Appealing Medicare Audit Decisions

If a Medicare contractor determines the Centers for Medicare & Medicaid Services (CMS) has overpaid your provider for a beneficiary's health services, the provider will receive notification of the overpayment amount. CMS will send the provider a demand letter requesting repayment and explaining that interest will begin to accrue if the overpayment is not received within 30 days. CMS may send the provider a second demand letter if it does not receive a response in a timely matter.

If you do not repay the overpayment amount or make payment arrangements within 40 days of the original demand letter, CMS will begin recoupment procedures to recover the overpayment amount by withholding funds from currently due payments or from future claims.



You can respond to a demand letter by refunding the overpayment, requesting an extended repayment plan, or filing an appeal. If you disagree with the audit determination, there are five levels of appeals you can use to contest CMS' repayment demand.

Note: Each state's Medicaid program is free to establish its own appeal procedures, but they will likely resemble the processes established for Medicare claims.

Rebuttals

A physician or supplier has 15 days from the date of the demand letter to file a rebuttal statement to the contractor explaining why CMS should not recoup the amount in question. A rebuttal statement is not a formal appeal, and will not forestall the recoupment process.

First Level: Redetermination

A provider who mounts an appeal, also known as an "appellant," must ask the Medicare contractor that made the original claim determination for a redetermination of its adverse audit decision. Members of the contractor's staff who did not participate in making the initial overpayment determination will conduct the redetermination.

The appellant must file the request for redetermination within 120 days from the receipt date of the initial audit determination; however, the appellant must file an appeal within 30 days of the demand letter to stop recoupment. No minimum dollar amount is required for a redetermination.

The Remittance Advice will include instructions for requesting a redetermination. Providers are encouraged to use form CMS-20027. If not using that form, a provider's written request for redetermination must include the beneficiary's name, the Medicare health insurance claim (HIC) number, the specific services for which the provider is requesting a redetermination, the dates of service, and the appellant's name and signature. The appellant should also include all supporting documentation with the request for redetermination. The Medicare contractor will usually respond with its decision within 60 days of receipt of the request.

Second Level: Reconsideration

If you are dissatisfied with the redetermination decision issued by the Medicare contractor, CMS hires qualified independent contractors (QICs) to conduct reconsiderations. You must file a request for reconsideration by a QIC within 180 calendar days of receipt of the redetermination decision. To stop the recoupment process, you must file the request for reconsideration within 60 days of the redetermination decision date.

A reconsideration allows a panel of physicians or other healthcare professionals to independently review the medical necessity determinations underlying the initial decision and redetermination. CMS encourages providers to submit a request for reconsideration using form CMS-20033, but a written request that contains the following will suffice:

- Beneficiary name;
- HIC number;
- Specific services for which reconsideration is sought;
- Exact date(s) of service;
- Name and signature of the party submitting appeal (or personal representative); and
- Name of the contractor that made the redetermination in question.

Provide a clear explanation of the rationale for disputing the redetermination, and a copy of the original remittance advice with the request for reconsideration. Provide the QIC with all pertinent documentation and other evidence supporting your challenge to the redetermination. If you do not provide evidence prior to the issuance of a reconsideration decision, you will not be able to submit relevant evidence in later stages of the appeal process without showing good cause.

The QIC will issue its decision within 60 days of the request for reconsideration. If the QIC cannot finish its review in time, it will inform you of your right to advance to the next appeal level.

Third Level: Administrative Law Judge Hearing

If you remain dissatisfied after the QIC's reconsideration decision, you can request an administrative law judge (ALJ) hearing if at least $140 remains in controversy. You must file the request within 60 days of receipt of the reconsideration decision. Appellants must serve all other parties to the QIC reconsideration with the request for an ALJ hearing. ALJ hearings are typically conducted via video teleconference or telephone. You may obtain an in-person hearing by demonstrating good cause for such a proceeding. ALJs will determine whether to grant in-person hearings on a case-by-case basis.

The ALJ sets the hearing procedures. CMS or its contractors may be a party to the hearing with notice to the ALJ and all parties. Generally, the ALJ will issue a decision within 90 days of his or her receipt of the hearing request. This deadline may be extended for reasons such as the submission of additional evidence or a request for an in-person hearing. If the ALJ fails to issue a decision within the allotted time, the appellant may request the ALJ to escalate the case to the next level of appeal.

Fourth Level: Appeals Council Review

Any party dissatisfied with the result of the ALJ hearing may request the appeals council to review the case. There is no monetary minimum threshold for appeals council review. The appellant must request this review in writing within 60 days of receipt of the ALJ's decision, and the request must identify the contested issues and findings. The appeals council will typically issue a decision within 90 days of receipt of the review request. If the appeals council fails to issue a decision within the allotted timeframe, the appellant may request the appeals council to escalate the case to the final appeal level.

Fifth Level: Judicial Review in U.S. District Court

Finally, a party dissatisfied with the appeals council decision can appeal that decision to the U.S. District Court if at least $1,400 remains in controversy after the council decision. The dissatisfied party has 60 days after the appeals council decision to request such review.

Consult your legal counsel throughout the appeal process. Legal representation is particularly important at this repayment appeal level.

Mea Culpa: Settlements

If you determine the provider's documentation was deficient, or coding and/or billing was inaccurate, you may wish to approach the payer about settling the dispute. Medicare and Medicaid recovery audit contractors (RACs) are unable to settle claims with providers, but CMS or the state equivalent can. Private insurance companies regularly settle with providers to resolve payment disputes.

When deciding whether to approach a payer about a settlement, double-check your coding and billing and the payer's audit sampling and extrapolation.

When deciding whether to approach a payer about a settlement, double-check your coding and billing and the payer's audit sampling and extrapolation. Consult legal counsel regarding whether to attempt to negotiate a settlement with the payer. Calculate the payer's error rate, which is the percentage of cases the payer has incorrectly identified as problematic: The higher the payer's error rate, the stronger your negotiating power.

Providers can make concessions that may facilitate settlement. For example, a provider may commit to improved education and training of physicians, billers, and/or coders; follow-up audits to verify the provider has implemented the agreed-upon corrections; or community service, such as physicians providing teaching opportunities at local medical schools.

Ideally, a settlement agreement should prevent the payer from future "look backs." The agreement should settle the parties' dispute with finality, and the payer should agree not to challenge future payments involving the same issue that occurred prior to the settlement. Negotiate for the billing errors to be characterized as administrative errors; and make sure there are no citations, indicia, or allegations of fraud or abuse in the settlement agreement.

If you have agreed to implement changes, such as training or changes in billing procedures, negotiate for enough time to fulfill those obligations (usually 60 or 90 days). Your legal counsel should negotiate the settlement agreement language and draft or review the agreement before you sign it.

If you have any questions or require additional information, please contact the authors. HBM

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Coding Compass: Facility

Understand What Constitutes a Hospital Admission

A revision to the 2014 IPPS final rule helps to clarify the "two-midnight" rule.

By Julie E. Chicoine, Esq., RN, CPC, CPCO

All too often, chronically ill, medically fragile patients present to a hospital's emergency department (ED) or outpatient clinic with exacerbation of chronic problems the patient and family members cannot manage alone. In some cases, the patient may be "admitted" for observation status, only to find out later that his or her care did not constitute a true "inpatient" hospital admission, which results in unexpected financial costs. Equally frustrating is when hospitals are concerned about Medicare Part A payment rejection from Medicare administrative contractors (MACs) and/or recovery audit contractors (RACs) for these "outpatient services" when it's not clear the patient's condition merits an inpatient admission.

To ensure compliance with the two-midnight rule, CMS clarifies in the revision that it will defer to the physician's clinical judgment as to whether a beneficiary's complex situation and "risk of morbidity or mortality" merits inpatient hospital admission.

CMS Provides Clarification

In light of these challenges, the Centers for Medicare & Medicaid Services (CMS) issued a revision to the 2014 Inpatient Prospective Payment System final rule (CMS-1599-F, published Aug. 19, 2013), as well as subsequent guidance and answers to frequently asked questions (FAQ) to clarify CMS payment policy for inpatient hospital and critical access hospital (CAH) admissions.

Per these collective documents, and in addition to services CMS has designate as covered inpatient services, additional care such as surgical procedures, diagnostic tests, and "other treatments" is appropriate for inpatient hospital admission and payment under Medicare Part A when the physician:

- Expects the patient to require a stay that spans at least two midnights; and
- Admits the patient to the hospital based upon that expectation.

Note: CMS clarifies that procedures defined as "inpatient-only" are not included in the two-midnight rule and may be furnished on an inpatient basis regardless of the beneficiary's length of stay.

The following summarizes key requirements for compliance with the two-midnight rule.

Physician Order/Certification: CMS clarifies that a Medicare beneficiary is considered a hospital inpatient when formally admitted pursuant to an order for inpatient admission by a physician (or other qualified practitioner). The medical record must include the physician's order and certification, documenting:

- Authentication – the physician must certify the inpatient admission orders comply with Medicare regulations and services are reasonable and necessary;
- Reason for the inpatient services;
- Estimated time the beneficiary requires to be in the hospital; and
- Plans for post hospital care.

Certification begins with the order for inpatient admission and must be furnished (verbal orders permitted) "at or before the time of the patient's admission." CMS makes it clear that retroactive orders are unacceptable.

Factors to Consider when Admitting a Patient

To ensure compliance with the two-midnight rule, CMS clarifies in the revision that it will defer to the physician's clinical judgment as to whether a beneficiary's complex situation and "risk of morbidity or mortality" merits inpatient hospital admission. For payment, CMS will look for documentation that supports such a decision, including "the beneficiary's age, disease processes, comorbidities, and the potential impact of sending the beneficiary [safely] home."

Timeframe

Per CMS, the timeframe used in determining the two-midnight stay begins when "care" in the hospital begins. Care includes all of the time the beneficiary has spent in the hospital receiving services in outpatient observation, the ED, an operating room, or other treatment areas in the hospital. CMS, however, emphasizes that the time a beneficiary spends waiting for care (i.e., in the ED triage or waiting area) before the formal inpatient admission order is *not* considered inpatient time.

Note: The ambulance time prior to arrival at the hospital does not start the clock for calculating the two-midnight benchmark.

Documentation

In clarifying that "no specific procedures or forms" are required for certification, CMS provides guidance to contractors reviewing claims under this new benchmark (see "Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013," http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/ReviewingHospitalClaimsforAdmissionFINAL.pdf).

CMS guidance states that medical record documentation "must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights."

In terms of what would constitute sufficient documentation, CMS's FAQ publication advises, "sufficient documentation will be rooted in good medical practice," meaning that documentation must support the med-

ical necessity for the level of services rendered. CMS further states that the "[e]xpected length of stay and the determination of the underlying need for medical or surgical care at the hospital must be supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which review contractors will expect to be documented in the physician assessment and plan of care."

Outreach and Education Cases Provide Guidance

In regard to the new standard, CMS continues outreach and education efforts and hosted an *MLN Connects*™ National Provider Call on Jan. 14, 2014. This call provided an overview of the inpatient hospital admission and medical review (payment) criteria. As part of the call, CMS provided six case scenarios to illustrate how to apply the two-midnight rule to sample medical records. Let's take a look at two of them:

photo by iStockphoto/Thinkstock

CMS will not pay for social and custodial care, convenience factors, or wait times when calculating the two-midnight benchmark in this scenario.

Case Scenario 3: Treatment in the ICU (paraphrased)**:**

Dec. 1 at 9:00 a.m., a 73-year-old male with accidental environmental toxic exposure presents to the emergency department via ambulance. He is awake and alert.At 9:03 a.m., Poison Control is consulted. They advise that the patient requires telemetry monitoring, and to plan to intubate as needed. Because the hospital facility is small, telemetry monitoring is only available in their ICU. At 9:07 a.m., therapeutic and diagnostic modalities are ordered and initiated, and the patient's airway remains intact. At 10:00 a.m., the physician requests transfer to the ICU for telemetry monitoring. At that time, the physician is unsure whether the patient will need medically necessary hospital-level care or services for two or more midnights. This determination depends on the clinical presentation and the diagnostic tests results.

Dec. 2 at 10:30 a.m., the medical concerns are resolving, and the airway continues to remain intact. At 12:00 p.m., the physician determines the patient is safe for discharge home.

This should be billed as an outpatient claim for services. When billing this to Medicare, the location does not matter because, according to Melanie Combs-Dyer, acting director of the CMS Provider Compliance Group, "despite the placement in the intensive care unit, the decision still should be centered around whether or not the physician expects the beneficiary to remain in the hospital for medically necessary services for 2 or more midnights." (See FAQ 4.4).

Case Scenario 6: Medical Necessity (paraphrased)**:**

Nov. 9 (Saturday), a 78-year-old male with a past and current medical history of chronic illnesses well controlled with medication presents alone to the emergency department at 7:30 p.m., following a fall from home. He slipped while shoveling, fell, and sustained a closed wrist fracture. At 11:30 p.m., the patient's arm fracture is confirmed by the practitioner and pain medication is provided.

Nov. 10 (Sunday) at 3:30 a.m., the patient's pain is well controlled, and he is stable for discharge, but he requires custodial care. No family or friends are available, and the hospital social services are unavailable until Monday morning. He is held in the hospital pending a home care plan, has no IV access, and his pain is well controlled with oral medication.

Nov. 11 at 10:00 a.m. (Monday) morning, the patient is released to home with a family member. No other complications are noted.

In this scenario, it would be appropriate to bill Medicare for the outpatient services only. CMS will not pay for social and custodial care, convenience factors, or wait times when calculating the two-midnight benchmark in this scenario.

"The patient must be receiving medically necessary hospital care, and if a beneficiary is kept in the hospital beyond 2 midnights, but it appears that the beneficiary is kept solely for purposes of systematic gaming or abuse in order to surpass the 2-midnight presumption, this claim may be reviewed by Medicare review contractors," Combs-Dyer said.

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Find Out More

CMS is still making decisions in regard to two-midnight rule rare and unusual circumstances, and is accepting submissions for evaluation at IPPSAdmissions@cms.hhs.gov.

To read the "2-Midnight Benchmark for Inpatient Hospital Admissions *MLN Connects*™ National Provider Call" transcript, go to www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/01-14-14-2Midnight-transcript.pdf. You can also download presentation materials from www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-01-14-Midnight-Presentation.pdf. HBM

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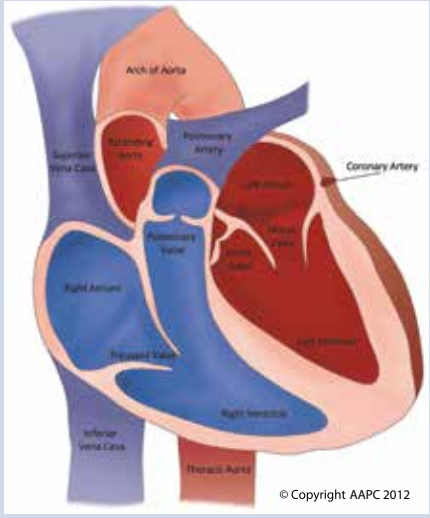
Links for additional information on the two-midnight rule:

- Final rule: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html
- FAQ: www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf
- Inpatient hospital reviews: http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html

ICD-10-CM Tip

Heart Valve Function

The valves of the human heart (tricuspid, mitral, pulmonary, and aortic) are fibrous cusps that help regulate the flow of blood through the heart by opening to permit blood flow and closing to prevent backflow. There are two atrioventricular valves, the tricuspid and mitral valves, which get assistance opening and closing by the chordae tendineae. The chordae are tendons consisting mostly of collagen that link the papillary muscles to the tricuspid valve and the mitral valve. When the papillary muscles contract and relax, the chordae transmit an increase or decrease in tension to the valves, causing them to open or close. There are two semilunar valves, the aortic and pulmonary, which gauge pressure to determine when to open and close.



By Lanaya Sandberg, MBA, CPCO

Added Edge

ICD-10 Conversion Takeaways for Health Plans

Understand ICD-10's effects on healthcare plans, and take steps to pave the way to a smooth conversion.

The Centers for Medicare & Medicaid Services (CMS) is propelling the healthcare industry to adopt HIPAA 5010 transaction standards and the ICD-10 code set to leverage advancements in healthcare technology—namely, electronic healthcare records (EHR)—for the purpose of reducing government spending. These upgrades are also occurring because code categories are full, and ICD-9-CM codes do not always offer the desired specificity.

ICD-10 Value Proposition

The purpose of ICD-10 implementation is to improve clinical communication through precise documentation and comprehensive reporting of quality measures, advancing clinical quality outcomes. Health plans will benefit from the greater clinical communication and detail that ICD-10 codes offer. For example, health plan medical management departments may be able to more promptly identify members who should be enrolled in case management programs.

As the Oct. 1, 2014 compliance date approaches, recognize that the ICD-10 transition may affect health plans in several ways. If you are a healthcare plan, consider the following ICD-10 conversion takeaways:

1. Collaboration and Education

Collaborate with significant healthcare providers for testing purposes. As the ICD-10 conversion will require changes to your health plan system, configure and test well in advance of Oct. 1.

Create and distribute provider educational materials as soon as possible. To mitigate risks, work closely with major clearinghouses. You should also establish specific goals (e.g., foreseeable revenue and costs) related to your ICD-10 conversion strategy (and to which providers also can relate), and publically disseminate these goals.

2. Payment Accuracy

Although ICD-10 won't transform provider reimbursement, it will facilitate reimbursement methodologies that more precisely reflect member status and care. Specifically, providers may experience:

- Better discovery of fraud, waste, and abuse;
- Improved coordination of care across the healthcare delivery continuum;
- Better case management;
- More transparent provider performance reporting; and
- Improved patient centered medical home and pay-for-performance initiatives.

3. Systems Assessment

You should conduct a thorough analysis of all the health plan's systems affected by the ICD-10 conversion. This may include claims adjudication systems and contract management software.

4. Recommended Steps

The following are suggested actions, in chronological order, for health plans to take in preparation for the ICD-10 conversion:

Provider Steps

5. Collaborate with providers.

As the ICD-10 conversion will require changes to your health plan system, it's imperative for configuration and testing to occur well in advance of Oct. 1.

6. Identify and escalate risks.
7. Develop provider contracting strategies.
8. Execute any necessary provider contract legal documents.
9. Conduct testing with providers.

Finance Steps

1. Conduct assessment of those providers affected by the ICD-10 transition.
2. Determine which providers will be impacted the most.
3. Ascertain diagnosis related group (DRG) changes.
4. Update financial modeling based on any new provider contracting executed documents.
5. Monitor financials after implementation on Oct. 1, 2014.

System Steps

1. Update all systems to be ICD-10 compliant.
2. Make applicable DRG changes.
3. Update contract management software.
4. Update systems for ICD-10 Medicare severity-DRG (MS-DRG) conversion project.

Coder Preparation for ICD-10

For coders, AAPC recommends a five-step process to prepare for the Oct. 1, 2014 implementation of ICD-10:

1. ICD-10 Implementation Training
2. ICD-10 Anatomy and Pathophysiology Training
3. General Code Set Training
4. Specialty ICD-10 Code Set Training
5. ICD-10 Proficiency Assessment

Learn more at **www.aapc.com/icd-10coder**.

If you are interested in learning more about the ICD-10 conversion for health plans, visit CMS' payer resources website at: www.cms.gov/Medicare/Coding/ICD10/Payer_Resources.html. HBM

Editor's note: The views and opinions expressed in this article are those of the author and do not reflect the official policy or position of AAPC or any organization associated herein.

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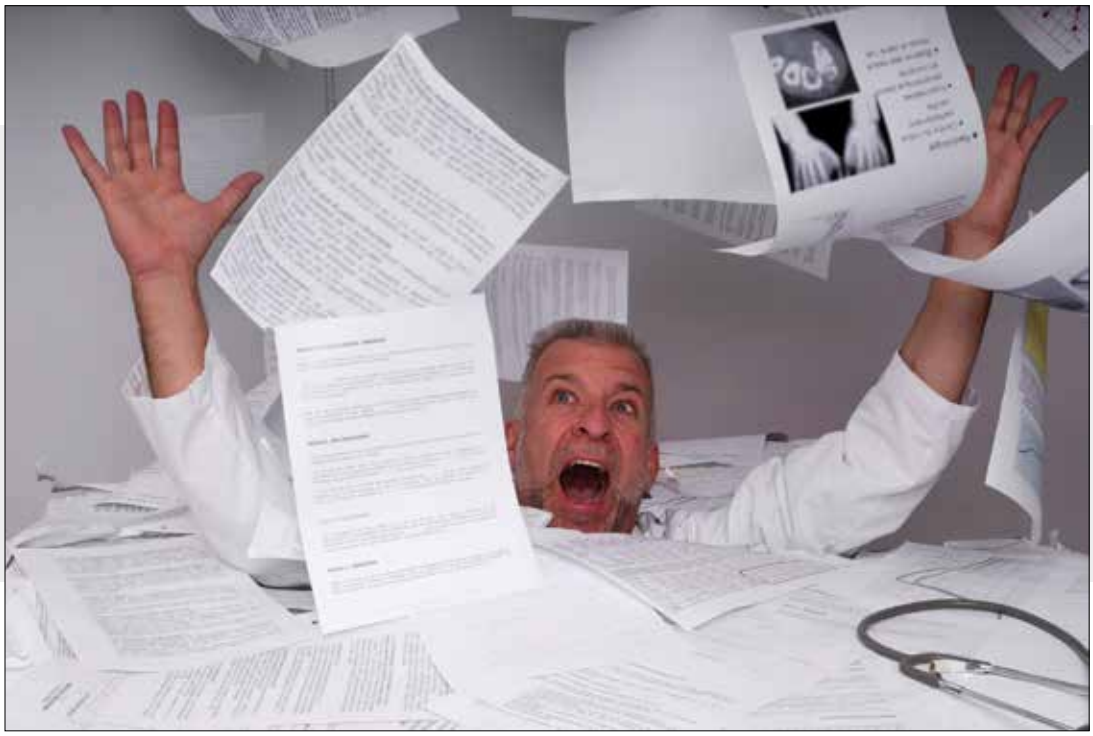
By Stephanie Cecchini, CPC, CEMC, CHISP

CDI: Lighten the Load for Physicians



Customize communication to help your practice meet CDI goals and objectives.

Clinical documentation improvement (CDI) has become a hot topic, especially as we gear up for ICD-10. The goal of CDI is for providers to augment their documentation processes to collect patient care data more fully, but also succinctly. In turn, coders are better equipped to code claims accurately and to the added specificity ICD-10-CM demands; and payers have the supporting data they need to process and appropriately pay claims. As logical as this sounds, you may encounter resistance.

Physicians May Cringe at CDI

According to the *M*edscape® Physician Compensation Report 2012, half of all physicians spend more than five hours per week on paperwork and other administrative activities. With so much effort devoted to non-clinical requirements and regulations, nearly half (46 percent) of physicians also say that if given another chance, they would not choose medicine as a career. For many providers, it's simply too hard to "buy in" when they see no correlation between the semantics required for medical documentation data elements and their true purpose in patient care.

To complicate matters, CDI education requires much more than subject matter expertise; it requires truly effective communication. Without a physician's buy-in, education is a very difficult objective to meet. Communication barriers between coders and physicians often create difficult and opposing points of interest. How, then, can a practice meet CDI goals and objectives?

Customize Communication

Make learning less of a chore for your physician by using a customized approach to communication. For example, a physician is more likely to listen and respond to communication that is succinct and based on fact. This may require a CDI expert and documentation assessment.

Coders are often excellent communicators for CDI issues because they understand both the mindset of the physician and documentation requirements.

Coders are often excellent communicators for CDI issues because they understand both the mindset of the physician and documentation requirements. The person selected to conduct CDI education must be an expert at both documentation assessment and communication. A documentation assessment allows the CDI expert to see where deficiencies exist, and tailor training to match the physician's unique learning style. A physician's medical specialty also plays a big part in narrowing the learning curve. For example, an orthopaedic surgeon doesn't need to learn documentation requirements for trimester notations in obstetrics care; nor do cardiologists need to know the requirements for documenting open fractures according to Gustilo classification.

If there are no coders in your practice who meet the qualifications, consider CDI outsourcing to help providers navigate complex documentation requirements. Analyze your practice to select the right CDI partner. The best partners are leaders who are capable of effective planning and producing quality deliverables. Practices that select CDI consultants based on their evaluation of a firm's reputation, experience, and service philosophy will have the best results. HBM

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By Serine A. Haugsness, CPC

Medical Coding Is Vital to Healthcare Data Analysis

Coding accuracy and completeness leads to better healthcare data.

Healthcare data have been used in public health for many years—hundreds, in fact! During the Black Death in London, England in 1664-1665, weekly *Bills of Mortality* were posted in public places to help warn citizens about how the plague was spreading within their communities. Today, such agencies as the Centers for Disease Control and Prevention and World Health Organization continue to gather and publish information about new and emerging infectious diseases, as well as more common infections such as influenza.

Healthcare data analyses are not limited to acute and infectious disease. Many chronic diseases, such as asthma and diabetes, are carefully studied and tracked. In fact, if you have a chronic disease, you may be enrolled in a disease management program through your employer and health insurer.

Look to Claims for Data Analysis

Medical claims are a smorgasbord of information. They contain member and provider demographics, dates, diagnoses, procedures, medications, and much more. Much of these data are protected health information as defined by HIPAA, and law prohibits release of information that can identify a specific person. But even redacted claims data (patient data that has been stripped of all "direct identifiers") provide relatively instant and easy insight into a large amount of valuable information. As part of the shift toward greater transparency, the Centers for Medicare & Medicaid Services (CMS) has made redacted Medicare claims data available for purchase. These are known as Basic Stand Alone Medicare Claims Public Use Files, and anyone can apply to access them.

Because claims are submitted in a standardized format, databases can be created easily to house the data in structured ways. Data analysts can pull information from these large databases to perform everything from a simple analysis (How many people in this clinic were diagnosed with influenza in the month of January?), to complex statistical modeling that uses past claims information to predict the future (When is flu season likely to hit Texas?). Analysis of claims data can be used to identify problem areas within a population, and subsequently to develop strategies to keep patients healthier.

Although claims are probably the most widely used source of data today, technology is constantly evolving. Electronic health records capture information, such as vital signs, laboratory test results, and other data elements that are not captured on claims. Provider and other healthcare professionals' documentation and optical character recognition (OCR) technology can "read" those images and pull out elements that might be meaningful to the data analyst. This technology is still being developed; therefore, handwritten chart documentation and image quality problems can pose challenges to gathering complete and accurate data. Even with these limitations, the prospects for OCR technology in retrieving healthcare data are exciting.

… good coding practices lead to better data. Better data lead to better medical decisions. Better medical decisions lead to better patient outcomes.

Why Care About Healthcare Data?

It's simple: Medical coders translate medical record documentation into the alphanumeric language of which healthcare data consists. Quality and accuracy in medical coding doesn't just affect the revenue cycle—although that is an important part of the claims process—it also directly affects the quality of healthcare data.

The quality of claims data can positively or negatively affect provider reimbursement (programs such as CMS' Physician Quality Reporting System (PQRS) or other pay-for-performance measures), or cause incorrect hospital diagnosis-related group (DRG) payment due to improper diagnosis code sequencing. Incorrect and incomplete diagnosis coding can adversely affect patient care by indicating the presence of disease where it does not exist, and not revealing the presence of a disease where it does exist. This can affect the accuracy of quality measurements such as the Healthcare Effectiveness Data and Information Set. Ultimately, it can lead to patients not being identified for case management where they may need extra support.

It all boils down to doing what's right. What is required is striving to code accurately and completely, according to all applicable federal, state, and local regulations, and following coding guidelines for all code sets (CPT®, HCPCS Level II, and ICD-9-CM). More than that, good coding practices lead to better data. Better data lead to better medical decisions. Better medical decisions lead to better patient outcomes.

Whether you're a coder or a nurse, physician, or hospital administrator, and whether you work at a payer or a medical school, we all want the same thing. We all want the health of our patients, communities, friends, and family to be better. By upholding high standards for medical coding, we have a direct influence on making that happen. HBM

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Check the References to Get the Facts

- www.resdac.org/
- Regarding the press release from CMS on Dec. 5, 2011, detailing the release (for a fee) of de-identified Medicare claims data, go to: www.cms.gov/apps/media/press/release.asp?Counter=4206&intNumPerPage=1000&checkDate=&checkKey=&srchType=1&numDays=0&sr.
- More about public use of Medicare claims database can be found at www.fiercehealthcare.com/story/cms-opens-medicare-claims-data-provider-quality-reports/2011-12-06.
- London's *Bills of Mortality* 1664-1665 images can be found at http://chnm.gmu.edu/cyh/primary-sources/159.
- www.cms.gov/site-search/search-results.html?q=public%20use%20files
- www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/BSAPUFS/index.html?redirect=/bsapufs/
- OCR: www.computerworld.com/s/article/73023/Optical_Character_Recognition

By Kelly Loya, CPC-I, CHC, CPhT, CRMA

DME Scrutiny Increases: Fix Documentation Misses

Although determining supply codes is pretty straightforward, diagnosis coding and medical necessity is not.

When it comes to durable medical equipment (DME), the most important risk for non-government payers is who pays for the items—the patient or the insurance. For government payers, the requirements for supporting documentation are more critical. To give you a better understanding of their importance, let's focus on the basics of documentation as it applies to Medicare for DME (The guidance may affect Medicaid and commercial payer coverage, also).

The Truth About DME

Everyone knows DME coding and billing is a "piece of cake." The DME supplier applies a predetermined HCPCS Level II code based on characteristics of the supply. Modifiers for certain claim types can be applied relatively easily, based on the details of the delivered supply.

While coding for the supply is often straightforward for most suppliers, determining the appropriate diagnosis code can be tricky. The ICD-9-CM code is the first link to support medical necessity of ordered item(s).

A denial or recoupment of a DME payment occurs most often when the ordering clinician does not properly document medical necessity. There are two types of orders: The preliminary or *dispensing order*, and the *detailed written order (DWO)*.

The **dispensing order** is usually a written or verbal communication documented by the supplier, which explains which item(s) is needed and when. Only basic information is required, and may be documented by the supplier alone; however, a claim for the dispensed item can be filed only after the DWO is received.

DWO documentation elements vary, depending on the ordered DME supply and payment category. Basic order requirements that always must be present include:

1. Patient (beneficiary) name
2. Prescribing physician's name
3. Detailed item description, including any modifications
4. Dispense quantity
5. Order date and start date (if different than the order date)
6. Physician signature *and* physician signature date

Additional information is required for supplies provided on a periodic basis. Elements of the order need to include the strength and/or frequency of use, and the number of refills, as applicable.

Sign and Date Is More than a Formality

Often, upon review of supporting DME records, the DWO's signature is lacking a date personally noted by the signing physician, or does not adhere to Medicare's signature requirements, as set forth in the *Medicare Program Integrity Manual*, chapter 3, section 3.3.2.4.

The physician must personally (either by hand or electronically) sign the DWO *and* date the signature. Signature stamps are unaccept-

The DME supplier is receiving the reimbursement for the item dispensed and is just as liable for Medicare fraud as the provider.

able. Even if the physician's staff completes the order, the physician must personally sign and date the DWO.

"If the supplier does not have an order that has been both signed and dated by the treating physician before billing the Medicare program, the item will be denied as not reasonable and necessary," according to DME Medicare administrative contractor (MAC) supplier manuals.

This requirement may seem trivial, but the timing and intent of the order cannot be validated if the physician does not personally note the date. The order is by far the most important document to support a medical need for DME based on clinical judgment. Merely having the DWO to support the codes submitted on the claim does not support the medical necessity. There must be corroborating evidence documented in the medical record.

Clearly Demonstrate the Need

Insufficient documentation to support basic coverage criteria is another common deficiency. Remember: The physician's order is not considered part of the patient's medical record. The DME MAC supplier manual and the *Medicare Program Integrity Manual*, chapter 5, section 5.2.3, state, "A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record."

For the DME supplier to be certain all coverage criteria is supported, the supplier should request the treating provider's notes, which lead up to and include ordering of the supply (at a minimum). DME suppliers may need a standard process, requiring all received DWOs to be accompanied by the ordering/treating physician's documentation.

The diagnosis supporting the supply's necessity must be present in the medical record. Upon review of the order and supporting medical record, discrepancies are often seen between the DWO and the progress note. If the condition necessitating the supply is in question, the supplier should seek clarification.

Some supplies also require the patient to complete a follow-up evaluation with his or her treating physician to verify the ordered equipment or supply is effectively improving or stabilizing the patient's condition. The supplier should not only validate the initial supporting information is within the medical record, but also that the follow-up evaluation is completed and continues to support medical necessity. Depending on the supply dispensed, the supplier should verify that the medical record justifies each additional element added to the supply or accessories provided, and the purpose for use.

Why is the DME supplier responsible for what is contained in the physician's record? The answer is simple: The DME supplier is receiving the reimbursement for the item dispensed and is just as liable for Medicare fraud as the provider.

DME Is for Home Use

Lastly—and perhaps one of the most important factors for coverage—consider where the patient is located, and his or her status.

DME is a Part B benefit; therefore, the ordered device or supply is for use in the patient's home. This doesn't mean the patient can't use the item outside the home; however, Part B coverage is only valid if it maintains or improves the patient's daily living activities in the home or place of residence. A patient is ineligible to receive the Part B benefit for DME supplies while receiving a level of care covered under Part A because the facility would be responsible for providing the necessary DME for the patient's use while in the facility.

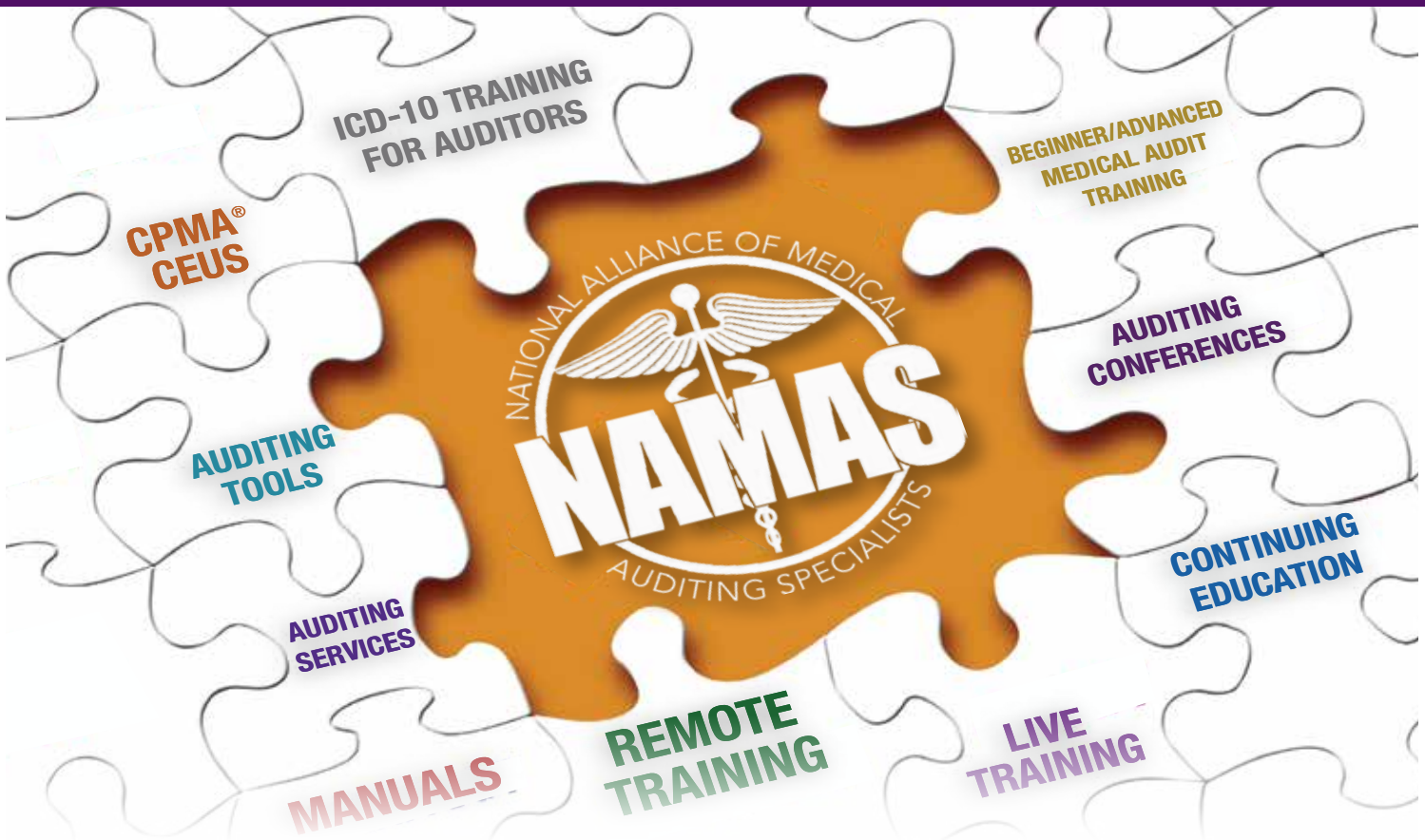
DME Under Surveillance

DME is under a microscope like never before. With the increased scrutiny of government funded healthcare reimbursement, and the high error rates in this area, the Office of Inspector General and DME MACs are on the alert. Many MACs, such as Jurisdiction B MAC Noridian Healthcare Solutions, are conducting widespread prepayment reviews and are publishing the results on their websites. HBM

Kelly Loya, CPC-I, CPhT, CHC, CRMA, is director of Reimbursement Advisory Services at Altegra Health, Inc. She has more than 25 years of experience in medical coding, billing, reimbursement, internal audit, compliance, and clinical operations. Loya also assists clients with litigation support services for related areas of focus, including data analysis and statistical sampling services. She is a member of the Charlotte, N.C., local chapter.

Resources:

- CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, chapter 5, sections 5.2.3, 5.8
- Social Security Act, sections 1833(e), 1879, 1861(r)
- 42 CFR, section 405.841(c)(1)
- CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, chapter 20
- Noridian medical reviews, www.noridianmedicare.com/dme/reviews/medical_review.html



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Betty Lynn Gould, **CPC-A**
Betty McDaniel, **CPC-A**
Beverly Sue Becker, **CPC-A**
Bharath Chandrakesavan, **CPC-A**
Bhuvaneswari Muruganandham, **CPC-A**
Bill Howell, **CPC-A**
Billie Ann Bevels, **CPC-A**
Bindu Issac, **CPC-A**
Bindu Jimmy, **CPC-A**
Bobbie Harper, **CPC-A**
Bonnie Brklacich, **CPC-A**
Bonnie Mae Weaver, **CPC-A**
Bonnie Marie Morgan, **CPC-A**
Brandy Donbeck, **CPC-A**
Brandy Kubischta, **CPC-A**
Breanna Simeona, **CPC-A**
Brenda Keels, **CPC-A**
Brenda Murfin, **CPC-A**
Brenda Tinerella, **CPC-H-A**
Brenda Torres, CPC-A, **CPC-H-A**
Brian Lloyd Baker, **CPC-A**
Brianna Thompson, **CPC-A**
Bridget Corns, **CPC-A**
Bridget Davisson, **CPC-A**
Bridget Hood, **CPC-A**
Bridget L. Ruehmann, **CPC-A**
Bridgett Bowling, **CPC-A**
Bridie Noel Fortier, **CPC-A**
Bright King John Asirvadam, **CPC-A**
Brittany Ann McWilliams, **CPC-A**
Brittany Balch, **CPC-A**
Brittany Smith, **CPC-A**
Brittney Welling, **CPC-A**
Bunthoeun Nuon, **CPC-A**
Candace Hardy, **CPC-A**
Candice S Drakeford, **CPC-A**
Candice Williams, **CPC-A**
Cari Bunch, **CPC-A**
Carlye M Hansen, **CPC-A**
Carmelita Lorenzo, **CPC-A**
Carmen Davis, **CPC-A**
Carmen J Badillo, **CPC-A**
Carmen M Tempone, **CPC-A**
Carol Hebert, **CPC-A**
Carol Thomas, **CPC-A**
Carolyn Jelinek, **CPC-A**
Carolyn Marie King, **CPC-A**
Carolyn Redden, **CPC-A**
Carrie Cromer Harmon, **CPC-A**
Carrin Fuller, **CPC-A**
Carynne Pierzchalski, **CPC-H-A**
Casey Lynn Mele, **CPC-A**
Casey Pearson, **CPC-A**
Cassandra Lee Burger, LPN, **CPC-A**
Cassandra Slette, **CPC-H-A**
Catherine Ann D'Aquila, **CPC-A**
Catherine Burroughs, **CPC-A**
Catherine Hullett, **CPC-A**
Cathleen Smith, **CPC-A**
Celin Simon, **CPC-A**
Chalapathi Rao Menda, **CPC-H-A**
Chandrakant Garudachar, **CPC-A**
Charanya Ramula, CPC-A, **CPC-H-A**
Charity Renee Herrin, **CPC-A**
Chelsea Clements, **CPC-A**
Chelsea Smith, **CPC-A**
Cherie L Finley, **CPC-A**
Cheryl A Reincke, **CPC-A**
Chinchu Merin Mathew, **CPC-A**
Chinni Kumari Bhimisetty, **CPC-A**
Chinta Samhitha, **CPC-A**
Chris Gilbert, **CPC-A**
Chris Pevytoe, **CPC-A**
Christa Phillips, **CPC-A**
Christian Dismute, **CPC-A**
Christian Dixon, **CPC-A**
Christina Alvarado, **CPC-A**
Christina Benevides, **CPC-A**
Christina Cabanillas, **CPC-A**
Christina Delos Santos Rosales, **CPC-A**
Christina Eastwood, **CPC-A**
Christina Lee, **CPC-A**
Christina Llampay-Medina, **CPC-A**
Christina M Callahan, **CPC-A**
Christina Montoya, **CPC-A**
Christine Benito, **CPC-A**
Christine Comeaux, **CPC-A**
Christine Cyr, **CPC-A**
Christine Diane Ingvalson, **CPC-A**
Christine Rebecca Carter, **CPC-A**
Christy Karren, **CPC-A**
Christy Smith, **CPC-A**
Chyleina Kay Herron, **CPC-A**
Cindi Brau, **CPC-A**
Cindy Case, **CPC-H-A**
Cindy Conner, **CPC-A**
Cindy Lawrence, **CPC-A**
Cindy Lee McCurley, **CPC-A**
Cindy Verhovshek, **CPC-A**
Claire Mitchell, **CPC-A**
Claudia Gonzalez, **CPC-A**
Clifton Nickle, **CPC-A**
Coleen Chambers, **CPC-A**
Colette Nancy Henriquez, **CPC-A**
Conchita Theresa Brito, **CPC-A**
Connie Birth, **CPC-A**
Cori Ann Plaza, **CPC-A**
Courtney Ranabargar, **CPC-A**
Craig Laursen, **CPC-A**
Criste Melton, **CPC-A**
Crystal Buensuceso Cabag, **CPC-A**
Crystal Romat, **CPC-A**
Crystal Sullivan, **CPC-A**
Cyndi Baker, **CPC-A**
Cynthia Alegre, **CPC-A**
Cynthia Brown, **CPC-A**
Cynthia Devroy, **CPC-A**
Cynthia L Bermingham, **CPC-A**
Dalean VanBrocklin, **CPC-A**
Dana Bedar, **CPC-A**
Dana Jones, **CPC-A**
Dana S Handley, **CPC-A**
Daniel Grzesiak, **CPC-A**
Daniela McCroby, **CPC-A**
Danielle C. Murdock, **CPC-A**
Danielle Crochet, **CPC-A**
Danielle L'Shay Moore, **CPC-A**
Danielle Renee DeHart, **CPC-H-A**
Danielle Ribakow, **CPC-A**
Danielle Schaefer, **CPC-A**
Danielle Westbrook, **CPC-A**
Danijela Karan, **CPC-A**
Danny R Crum, **CPC-A**
Dara Morgan, **CPC-A**
Darla J.S. Wallace, **CPC-A**
Darlene Dean, **CPC-A**, CEMC
Darlene J Turner, **CPC-A**
Darlene Quintana, **CPC-A**
David Arturo Carras-Pol, **CPC-A**
Dawn Brown Toole, **CPC-A**
Dawn Mathews, **CPC-A**
Dawn Morris, **CPC-A**
Dawne Marie Tacheny, **CPC-A**
Debbie Jones, **CPC-A**
Debbie Kaplan, **CPC-A**
Debbie Louise Thacker, **CPC-A**
Deborah Ann Cacioli, **CPC-A**
Deborah Avolio, **CPC-A**
Deborah Dumont, **CPC-A**
Deborah Kabot, **CPC-H-A**
Deborah O'rourke, **CPC-A**
Deborah Smith, **CPC-A**
Deborah Sullivan, **CPC-A**
Debra Bowman, **CPC-A**
Debra Carr, **CPC-A**
Debra D Mick, **CPC-A**
Debra K Wilkinson, **CPC-A**
Debra Michelle Zohler, **CPC-A**
Debra Nelson, **CPC-A**
Debra Pennington, **CPC-A**
Debra Rose Edmonds, **CPC-A**
Deena Famfeelia Jayakumar, **CPC-A**
Deepa Raghunath, **CPC-A**
Deepak Kumar, **CPC-A**
Deidre L McBroom, **CPC-A**
Demesha Copeland, **CPC-A**
Deneen Hutchins, **CPC-A**
Deniese C Barringer, **CPC-A**
Devan Safer, **CPC-A**
Devi S. Chitrapu, **CPC-A**
Devika Mohan, **CPC-A**
Dhanajayan Suresh, **CPC-A**
Dhilip Palanisamy, **CPC-A**
Diana Erives, **CPC-A**
Diana Webster, **CPC-A**
Diane Bucon, **CPC-A**
Diane K Young, **CPC-A**
Diane L Broomall, **CPC-H-A**
Diane McNamara, **CPC-A**
Diane Sparks, **CPC-H-A**
Dionne McFarlane Cotterman, **CPC-A**
Divya Benraj, **CPC-A**
Divya Kapoor, **CPC-A**
Donghong Wang, **CPC-A**
Donna Carlstedt, **CPC-A**
Donna Cramer, **CPC-A**
Donna Hammonds, **CPC-A**

NEWLY CREDENTIALED MEMBERS

Donna Jacobs, **CPC-A**
Donna Little-Staten, **CPC-A**
Donna Masukawa, **CPC-A**
Donna Minter, **CPC-A**
Donna Parks, **CPC-A**
Dustin Schappell, **CPC-A**
E Ashley VanMeter, **CPC-A**
E Jewell Lawson, **CPC-A**
Eboni Rackley, **CPC-A**
Edward Godfrey, **CPC-A**
Edward T Allen, **CPC-A**
Eileen McGuire, **CPC-H-A**
Eileen Kay Pattarozzi, **CPC-A**
Ekaette Joseph-Isang, **CPC-A**
Elaine Crowley Watson, **CPC-A**
Elaine Brewer, **CPC-A**
Elbin Sebastian, **CPC-A**
Elilnidhi Palanikumar, **CPC-A**
Elizabeth Carreno, **CPC-A**
Elizabeth Allen, **CPC-A**
Elizabeth Cole, **CPC-A**
Elizabeth Earley, **CPC-A**
Elizabeth Napoles, **CPC-A**
Elizabeth Thornton, **CPC-A**
Ellen V Martin, **CPC-A**
Ellenann Gatza, **CPC-A**
Ellenlee Chun, **CPC-A**
Elsie Wright, **CPC-A**
Elyse Bergeron, **CPC-A**
Elysia Gail York, **CPC-A**
Eman M Kisba, **CPC-A**
Emilie Moss, **CPC-A**
Emily Caplan, **CPC-A**
Emma Jean Brown, **CPC-A**
Enoch Blatnick, **CPC-A**
Eppa Ravi, **CPC-A**
Erica Lews, **CPC-A**
Erica Nielsen, **CPC-A**
Ericka Watson, **CPC-A**
Erin Donovan, **CPC-A**
Erin Fitch, **CPC-A**
Erin Price, **CPC-A**
Erin Spring Rudisill, **CPC-A**
Esther Jayapriya Jayachandran, **CPC-A**
Esther Mark, **CPC-A**
Estrellita Castille, **CPC-A**
Eulalia Villegas, **CPC-A**
Evan April Deynata Capistrano, **CPC-H-A**
Evans Georges, **CPC-A**
Evelyn Lyle, **CPC-A**
Feneca J Carter, **CPC-A**
Fonda Lynn Jones, **CPC-A**
Fonda Renee Addison, **CPC-A**
Fonessa S Knuckles, **CPC-A**
Frances Lewis, **CPC-A**
Frances Pileggi, **CPC-A**
Francesca Marin, **CPC-A**
Gail Dunkle, **CPC-A**
Gail Rickaby, **CPC-A**
Gail Robin Harper, **CPC-A**
Gajalakshmi Murugesan, **CPC-A**
Gajendra Singh, **CPC-A**
Garima Thakur, **CPC-A**
Gemma Sobretodo, **CPC-A**
Genevieve M Schlichting, **CPC-A**
Genevieve Schroeder, **CPC-A**
Georgina Rameau, **CPC-A**
Geraldine Gadwa, **CPC-A**
Gina Marie Josefowicz, **CPC-A**
Gina Schultz, **CPC-A**
Ginette Krumrie, **CPC-A**
Giselda Hernandez, **CPC-A**
Gloria Yang-Kolodji, **CPC-H-A**
Gokul N Nagalingam, **CPC-A**
Gopi Subramani, **CPC-A**
Grace DeZern, **CPC-A**
Grace Muyco, **CPC-A**
Gregory Hall, **CPC-A**
Gufran Ali, **CPC-A**
Gwendolyn Tysor, **CPC-A**
Habeebur Rahman Bakshi Gulam, **CPC-A**
Hannah Gerig, **CPC-A**
Hari Polarpu, **CPC-A**
Hariharan Muruganantham, **CPC-A**
Hariprasad Malladi, **CPC-A**
Harsh Vyas, **CPC-A**
Harshini Koyya, **CPC-A**
Heather Bradley, **CPC-A**
Heather Rice, **CPC-H-A**
Heather Stone, **CPC-A**
Heather Woods, **CPC-A**
Heidemarie Quirk, **CPC-A**
Helen Armstrong, **CPC-A**
Hemalatha Subramaniyan, **CPC-A**
Herbert Stewart, **CPC-A**
Hillary Kinnison, **CPC-A**
Holly Johnson, **CPC-A**
Holly Michele Gately, **CPC-A**
Hollyann Senk, **CPC-A**
Howie-Ann Ames, **CPC-A**
Ibrahim Fashina, **CPC-A**
Indumathy MaduraiMuthu, **CPC-A**
Ira Warlick, **CPC-A**
Irenia Valdes, **CPC-A**
Irina Markman, **CPC-A**
Irina Skoran, **CPC-A**
Isaiarasi Thirumamanalan, **CPC-A**
Iuliana Binda, **CPC-A**
Ivy Ebarsabal, **CPC-A**
Ivy Katrina Jacobe, **CPC-A**
Jacey Parson, **CPC-A**
Jackie Kiralla, **CPC-A**
Jacqueline LaZore, **CPC-A**
Jacqueline Staskal, **CPC-A**
Jade Elizabeth Johnson, **CPC-A**
Jafrulla Nirki, **CPC-A**
Jagadeesh S Munoli, **CPC-A**
Jaime Vega-Hernandez, **CPC-A**
Jaishree S Kamath, **CPC-A**
Jake Stephens, **CPC-H-A**
James Bell, **CPC-A**
James Steven Hidu, **CPC-A**
James Taylor, **CPC-A**
Jamie Fuller, **CPC-A**
Jamie Lake, **CPC-A**
Jamie Mckinney, **CPC-A**
Jamie Quaranta, **CPC-A**
Jamie Wagoner, **CPC-A**
Jane Meier, **CPC-A**
Janet C Buksa, **CPC-A**
Janet Denise Cunningham, **CPC-A**
Janet Hill, **CPC-A**
Janet Tummers, **CPC-A**
Janet Wood, **CPC-A**
Janet Yvette Blair, **CPC-A**
Janice Mary Kopf, **CPC-A**
Jascent Davis, **CPC-A**
Jascinth Thomas, **CPC-A**
Jason Huck, **CPC-A**
Jason Smith, **CPC-A**
Jason W Greene, **CPC-A**
Jayakumar Ramalingam, **CPC-A**
Jayne Blakeley Hovers, **CPC-A**
Jayne Grady, **CPC-A**
Jeanette Susan Keel, **CPC-A**
Jenifer Nelson, **CPC-A**
Jenifer Rajamanickam, **CPC-A**
Jenn Bise, **CPC-A**
Jennie Squire, **CPC-A**
Jennifer Ann Anderson, **CPC-A**
Jennifer Anne Veltrop, **CPC-A**
Jennifer Berghout, **CPC-A**
Jennifer Cheatham, **CPC-A**
Jennifer Collins, **CPC-A**
Jennifer Dipasquale, **CPC-A**
Jennifer Duell, **CPC-A**
Jennifer Encinias, **CPC-A**
Jennifer Houlker, **CPC-A**
Jennifer Kern, **CPC-A**
Jennifer Kinzel, **CPC-H-A**
Jennifer Michele Sousa, **CPC-A**
Jennifer Parker, **CPC-A**
Jennifer R Lance, **CPC-A**
Jennifer Riener, **CPC-A**
Jennifer Rose Begley, **CPC-A**
Jennifer S Wegner, **CPC-A**
Jennifer Sanders, **CPC-A**
Jennifer Smith, **CPC-A**
Jennifer Summitt, **CPC-A**
Jennifer Wupper, **CPC-A**
Jenniffer Grebs, **CPC-A**
Jessica Azucena Espinoza, **CPC-A**
Jessica Cesar, **CPC-A**
Jessica Gonzalez, **CPC-A**
Jessica Hubbard, **CPC-A**
Jessica L Knauer, **CPC-A**
Jessica Lynn Rogers, **CPC-A**
Jessica Steinke, **CPC-A**
Jessi-Charet K Martin, **CPC-A**
Jinkee Fuchs, **CPC-A**
Jo Kidd, **CPC-A**
Joan L Fernandez, **CPC-A**
Joann Madonia, **CPC-A**
JoAnn Nuttall, **CPC-A**
Joanna Lula, **CPC-A**
Joanna Nowak, **CPC-A**
Joanna Schuttler, **CPC-A**
Joanne DeWitt, **CPC-A**
Jodi Dupont, **CPC-A**
Jodie Dengler, **CPC-A**
Joe Thomas, **CPC-A**
John C Dederick, **CPC-A**
John Donovan, **CPC-A**
John W Jackson, **CPC-A**, CPMA
Johsira Cruz Ezammudeen, **CPC-A**
Joleen Monique Samuel, **CPC-A**
Joline Jackson Anderson, **CPC-A**
Jonar Naldoza Ninonuevo, **CPC-A**
Jordan Roe, **CPC-A**
Joseph R Harris, **CPC-A**
Joyce A Frye, **CPC-A**
Joyce Kates, **CPC-H-A**
Joyce LaJeunesse-Tapia, **CPC-A**
Joyce Wong, **CPC-A**
Jubin K J, **CPC-A**
Judy Hartsoe, **CPC-A**
Judy Williams, **CPC-A**
Julia Hobbins, **CPC-A**
Julianne Walsh, **CPC-A**
Julie Ann Walleck, **CPC-A**
Julie Anne Sabrina Sagum, **CPC-A**
Julie Edwards, **CPC-A**
Julie Neff, **CPC-A**
June Williams, **CPC-A**
Justin Leavitt, **CPC-A**
Kaitlyn Agnes Curry, **CPC-A**
Kalaiyarasan Adhimoolam, **CPC-A**
Kaleigh Ann Selan, **CPC-A**
Kara Baity, **CPC-A**
Karen Brown, **CPC-A**
Karen Elaine Christiano, **CPC-A**
Karen G Matlock, **CPC-A**
Karen Heon, **CPC-A**
Karen Kulick, **CPC-A**
Karen Learman, **CPC-A**
Karen Nunery, **CPC-A**
Karen Rae Todd, **CPC-A**
Kari Donohue, **CPC-A**
Karol Bundy, **CPC-A**
Karol Costello, **CPC-A**
Kasie Mae Cline, **CPC-A**
Kate Wickersham, **CPC-A**
Katherine Coombs, **CPC-A**
Katherine K Bliss, **CPC-A**
Kathirvel Chinnasamy, **CPC-H-A**
Kathleen Gloekler, **CPC-A**
Kathleen Mailloux, **CPC-H-A**
Kathleen Metoyer, **CPC-A**
Kathleen Yedinak, **CPC-A**
Kathy Hart, **CPC-A**
Katie Cook, **CPC-A**
Katie Graham, **CPC-A**
Katina Michaels, **CPC-A**
Katina Passer, **CPC-A**
Kayla Goff, **CPC-A**
Kazi Rudaba Ferdowsi, **CPC-A**
Keith King, **CPC-A**
Kelley Scrivens, **CPC-A**
Kellie Zastawny, **CPC-A**
Kelly Anne Scrobe, **CPC-A**
Kelly Carneal, **CPC-A**
Kelly Loxley, **CPC-A**
Kelly McConville, **CPC-A**
Kelly Smith, **CPC-A**
Kelly Swigart, **CPC-A**
Kelsey Leigh Kelley, **CPC-A**
Kelsie Porter, **CPC-A**
Kenneth John Cameron, **CPC-A**
Keri Fochs, **CPC-A**
Ketsia McClease, **CPC-A**
Kevin Karolian, CPC-A, **CPC-H-A**
Kevin Patrick Moran, **CPC-A**
Kevin Yeung, **CPC-A**
Kim J Evans, **CPC-A**
Kim Philbrook, **CPC-A**
Kim Stamos, **CPC-A**
Kimberley Wood, **CPC-A**
Kimberly Dawn Day, **CPC-A**
Kimberly Mooney, **CPC-A**
Kimberly Sparks, **CPC-A**
Kiran Kumar Jadala, **CPC-A**
Kodie Channel Cooper, **CPC-A**
Kondal Reddy Velaga, **CPC-A**
Kovid Ralli, **CPC-A**
Kranthikumar Thatipamula, **CPC-A**
Krishnakumar Sekar, **CPC-A**
Krista McGaha, **CPC-A**
Kristen Leigh Redmond, **CPC-A**
Kristen Moore, **CPC-A**
Kristen Parker, **CPC-A**
Kristi Trujillo, **CPC-A**
Kristie Graybeal, **CPC-A**
Kristie Smith, **CPC-A**
Kristin Hansen, **CPC-A**
Kristin Heckenlively, **CPC-A**
Kristin Kay Kloepping, **CPC-A**
Kristin L Short, **CPC-A**
Kristin Noble, **CPC-A**
Kristyn Bane, **CPC-A**
Krystel Hall, **CPC-A**
Kyle Christine Uczynski, **CPC-A**
Kyle Edwards, **CPC-A**
Lacey P Watkins, **CPC-A**
Lacie Morrison, **CPC-A**
Lakshmi. Arun Kumar, **CPC-A**
Lannette Wright, **CPC-A**
LaToya Chisholm, **CPC-A**
Laura Brown, **CPC-A**
Laura Davis, **CPC-A**
Laura Nichole Lindemann, **CPC-A**
Laura Woodard, **CPC-A**
Laura Wright, **CPC-A**
Laureen Finney, **CPC-A**
Laurel Blair, **CPC-A**
Laurel Bowen, **CPC-H-A**
Lauren Allport, **CPC-A**
Lauren Clague, **CPC-A**
Laurie Lucht, **CPC-A**
Leah Jennis, **CPC-A**
Leah Jones, **CPC-A**
Leah R Conrad, **CPC-A**
LeAnn Hamilton, **CPC-A**
Lee Crooks, **CPC-A**
Leena Chauhan, **CPC-A**
Lesley Sanzo, **CPC-A**
Libby Ann Winters, **CPC-A**
Lina M. Alonso, **CPC-A**
Linda Bauman, **CPC-A**
Linda C White, **CPC-A**
Linda Denise Rhodes, **CPC-A**
Linda Fitze, **CPC-A**, CPC-P-A
Linda Hawkins, **CPC-A**
Linda Myers, **CPC-P-A**
Linda Slade, **CPC-A**
Linda Wallace, **CPC-A**
Linda Wright, **CPC-A**
Lindsay Gomer, **CPC-A**
Lindsay Wilson, **CPC-A**
Lisa A Matley, **CPC-A**
Lisa Ann Fowler, **CPC-A**
Lisa Ann Sievers, **CPC-A**
Lisa Bobe, **CPC-A**
Lisa Clark, **CPC-A**
Lisa Flemion, **CPC-A**
Lisa M Mason, **CPC-A**
Lisa M. Binns, **CPC-A**
Lisa Maier, **CPC-A**
Lisa Merkow, **CPC-A**
Lisa Michlik, **CPC-A**
Lisa O'Connell, **CPC-A**
Lisa Palmer, **CPC-A**
Lisa Ripple, **CPC-A**
Lisa Smiddy, **CPC-A**
Lois Cole, **CPC-A**
Lonniette Walker, **CPC-A**
Lora Wilson, **CPC-A**
Lori Betag, **CPC-H-A**
Lori Hichens, **CPC-A**
Lori White, **CPC-A**
Lorraine Hall, **CPC-H-A**
Luanne Helen Mathwich, **CPC-A**
Lucie Contente, **CPC-A**
Lucille L Butcher, **CPC-A**
Lydia Allen, **CPC-A**
Machelle Clifton, **CPC-A**
Madhu Singarapu, **CPC-A**
Madhusudhan Anjaneyulu, **CPC-A**
Maegan Jones, **CPC-A**
Mahalakshmi Venkatesan, **CPC-A**
Mamta Shah, **CPC-A**
Mandy R Wilkins, **CPC-A**
Maneesh Kumar, **CPC-A**
Manischa Verbakel, **CPC-A**
Manuel Lauterio, **CPC-A**
Marappan Chinnu, **CPC-A**
Marcellina Dennis, **CPC-A**
Marcia Laing, **CPC-A**
Mareesa Ghuran, **CPC-A**
Margaret Ellen Reinholz, **CPC-A**
Margaret Migut, **CPC-A**
Maria Alexa Rendon, **CPC-A**
Maria Clarizza Labaco Nocum, **CPC-A**
Maria Coloma, **CPC-A**
Maria Quinn, **CPC-A**
Marianna Smith, **CPC-A**

NEWLY CREDENTIALED MEMBERS

(Apprentice continued)

Maribel Somers, **CPC-H-A**
Marie Michelakos, **CPC-A**
Marie A Sylvain, **CPC-A**
Marie Funchess, **CPC-A**
Marilesy Torres, **CPC-A**
Marissa Corradini, **CPC-A**
Mark Cureg, **CPC-A**
Mark Goodman, **CPC-A**
Mark Nemtzow, **CPC-A**
Marquitta Christopher, **CPC-A**
Martha Domanski, **CPC-A**
Martha Segraves, **CPC-A**
Mary Angela Bean, **CPC-A**
Mary Branick, **CPC-A**
Mary Cresence, **CPC-A**
Mary G Hanik, **CPC-A**
Mary Kathleen Kelly, **CPC-A**
Mary Lee Fortin, **CPC-A**
Mary Liz Steinacher, **CPC-A**
Mary Miller, **CPC-H-A**
Mary Robinson, **CPC-A**
Mary Sanchez, **CPC-A**
Mary Sinko, **CPC-A**
Mary Streeter, **CPC-A**
Mary T Fitzgerald, **CPC-A**
Mary Wolfe, **CPC-H-A**
Mary-Jo Hall, **CPC-A**
Masae Wise, **CPC-A**
Matthew Aaron Douglass, **CPC-A**
Matthew John Appel, **CPC-A**
Maurine Hamer, **CPC-A**
Megan Hirsch, **CPC-A**
Megan Jukich, **CPC-A**
Megan Phillips Hovermale, **CPC-A**
Megan R Wallace, **CPC-A**
Megan Tuquynh Pham, **CPC-A**
Melanie Ann Bradish, **CPC-A**
Meleah Woosey, **CPC-A**
Melinda Brooks, **CPC-H-A**
Melissa Cannizzio, **CPC-A**
Melissa Marie Tourangeau, **CPC-A**
Metilda Angel, **CPC-A**
Michael Anthony Torres, **CPC-A**
Michael Ditondo, **CPC-A**
Michele Fernandes, **CPC-A**
Michele L Bellis, **CPC-A**
Michele Summers, **CPC-A**
Michele Thieme, **CPC-A**
Michelle Burgos, **CPC-A**
Michelle Crawmer, **CPC-A**
Michelle L Poci, **CPC-A**
Michelle McClintock, **CPC-A**
Michelle Nelson, **CPC-A**
Michelle Rohde, **CPC-A**
Michelle Switzer, **CPC-A**
Michelle Vincil, **CPC-A**
Mick O'Hare, **CPC-A**
Millie Vega, **CPC-A**
Miranda Paige Hewson, **CPC-A**
Misty Herrel, **CPC-A**
Misty Tinch, **CPC-A**
Mohamed Jamaludeen, **CPC-A**
Mohamed Kasim Nisthar, **CPC-A**
Mohan Raja, **CPC-A**
Moka Ajay Kumar, **CPC-A**
Mona Youssef, **CPC-A**
Monday Reynolds, **CPC-A**
Monica Chinchilla, **CPC-A**
Moraith Bittel, **CPC-A**
Morgan Mills, **CPC-A**
Moriah Hilley, **CPC-A**
Mubarak Ali, **CPC-A**
Mubassir Thanivepil, **CPC-A**
Muhilan Shanmugam, **CPC-A**
Muni Balaji Meda, **CPC-A**
N Narmada Devi, **CPC-H-A**
Nadeem Ahmad, **CPC-A**
Nagma Mehboob, **CPC-A**
Nakia Dana, **CPC-A**
Nancy Haas, **CPC-A**
Nancy Ott, **CPC-A**
Nancy Powell, **CPC-A**
Natalie Aleman, **CPC-A**
Natalie Jennings, **CPC-A**
Natalie Koob, **CPC-H-A**
Nathaniel Vergara, **CPC-A**
NaveenKumar Vijayan, **CPC-A**
Nellie B Lewis, **CPC-A**
Nicole McGuire, **CPC-A**
Nicole Monique Rios, **CPC-A**
Nicole Pals, **CPC-A**
Nicole Purcell, **CPC-A**
Nicole Sweitzer, **CPC-A**
Nicole Yvonne Kastick, **CPC-A**
Nilanjana Gupta, **CPC-A**
Nilufer Latheef, **CPC-A**
Nina Reyes, **CPC-A**
Ninetta Isolani, **CPC-A**
Niraj Kumar Jha, **CPC-A**
Nirali Mehul Suthar, **CPC-A**
Nissi Anusha B, **CPC-A**
Norma Soraya Bravo, **CPC-A**
Nousheen S Saleem, **CPC-A**
Paige Brown, **CPC-A**
Paige Kennedy, **CPC-A**
Paige Thomasino, **CPC-A**
Pamela McDaniel, **CPC-A**
Parimala Durga Tavva, **CPC-A**
Parimala Shyamala, **CPC-A**
Patricia Allman, **CPC-A**
Patricia Ann Schroeder, **CPC-A**
Patricia Artz, **CPC-A**
Patricia Brace, **CPC-A**
Patricia D Bremer, **CPC-A**
Patricia L Harper, **CPC-A**
Patricia Marshall, **CPC-A**
Patricia Williams, **CPC-A**
Patty Karraker, **CPC-A**
Paul Murawski, **CPC-A**
Paula Bradshaw, **CPC-A**
Paula Hoffman, **CPC-A**
Paula Peterson, **CPC-A**
Paula Wright, **CPC-A**
Paulina Chon, **CPC-A**
Peggy Corchuelo, **CPC-A**
Peggy Toro Julian, **CPC-A**
Penny Carter, **CPC-A**
Peter Shivell, **CPC-A**
Peter T Autio, **CPC-A**
Phyllis Johnson, **CPC-A**
Pks Sekhar Kondreddi, **CPC-A**
Pooja Jaggi, **CPC-A**
Prabhu Kuppan, **CPC-A**
Prabu Duraisamy, **CPC-A**
Pradeepkumar Paduchuri, **CPC-A**
Prakash Manickam, **CPC-A**
Prakash Palanisamy, **CPC-A**
Prasad Duraisamy, **CPC-A**
Prasanna Kumar TM, **CPC-A**
Praveenya Thirunahari, **CPC-A**
Pravesh Kumar, **CPC-A**
Preeja C S, **CPC-A**
Priyadharsini Marisamy, **CPC-A**
Priyanka Somishetty, **CPC-A**
Priyanshee Yadav, **CPC-H-A**
Pujari Rajashekar, **CPC-A**
Pushpa Selvaraj, **CPC-A**
Rachael Woods, **CPC-A**
Rachel Andrekus, **CPC-A**
Rachel Elizabeth McKenzie, **CPC-A**
Rachel Lynn Veltrop, **CPC-A**
Rachel McKean, **CPC-A**
Rafiu Ajao, **CPC-A**
Raghunath Shanmugam, **CPC-A**
Rajasekaran Kasinathan, **CPC-A**
Rajitha Sramkuzhiyil Mani, **CPC-A**
Rama Thiagarajan, **CPC-A**
Ramachandran Murugesan, **CPC-A**
Ramesh Bingi, **CPC-A**
Ramya Priya Sowrirajan, **CPC-A**
Ranganadh Puppala, **CPC-A**
Ranjana Jaiswal, **CPC-A**
Raquel Fortoso, **CPC-A**
Rathi Thanikachalam, **CPC-H-A**
Ravinder Reddy Patel, **CPC-A**
Ray Leimkuehler, **CPC-A**
Rebecca Bailey, **CPC-A**
Rebecca Morgan, **CPC-A**
Rebecca Rizo, **CPC-A**
Reeta Braggs, CPC-A, **CPC-H-A**
Rena M Wallace, **CPC-A**
Renata Chase, **CPC-A**
Renate Dumbaugh, **CPC-A**
Renee Fedele, **CPC-A**
Renee I Beck, **CPC-A**
Renee Newman, **CPC-A**
Renee S Glass, **CPC-A**
Renee Ziegler, **CPC-A**
Renita Dearman, **CPC-A**
Renugapriya Kandasamy, **CPC-A**
Reshmi R Pillai, **CPC-A**
Revathi Anguswamy, **CPC-A**
Revathi Dhamodhran, **CPC-A**
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Rhonda Opitz, **CPC-A**
Robert Martin, **CPC-A**
Roberta L Ivey, **CPC-A**
Robin Dekker, **CPC-A**
Robin Elizabeth Buhl, **CPC-A**
Robin Lea Castellana, **CPC-A**
Robin Sullivan, **CPC-A**
Rocio Sanchez, **CPC-A**
Roopali Kalra, **CPC-A**
Rosana Tracey, **CPC-A**
Rosemarie Torrey, **CPC-A**
Rosemary Rouse, **CPC-A**
Rosi Lourdusamy, **CPC-A**
Rossella Tucker, **CPC-A**
Rowland Ruiz, **CPC-A**
Roxanna J Flaten, **CPC-A**
Ruchira Narayanan, **CPC-A**
Russell Manaay Ragay, **CPC-A**
Ruth Garafalo, **CPC-A**
S Thriveni, **CPC-A**
Sabra Lance, **CPC-A**
Saisushma Thotamsetty, **CPC-A**
Sally Atkinson, **CPC-A**
Samantha Denice Stokes, **CPC-A**
Samantha H Hall, **CPC-A**
Samantha Sharlene Ahlgren, **CPC-A**
Sandesh Chavanke, **CPC-A**
Sandi Tolin, **CPC-A**
Sandra Fedler, **CPC-A**
Sandra Hellebuyck, **CPC-A**
Sandra J Nelson, **CPC-A**
Sangeetha Chinnarasu, **CPC-A**
Sangeetha Duraisamy, **CPC-A**
Sangeetha Ramasamy, **CPC-A**
Sanjjay Kumar Kathiravelu, **CPC-A**
Santhosh Ellendula, **CPC-A**
Santhosh Ramavath, **CPC-A**
Santhosh Ravindranathan, **CPC-A**
Santosh Kumar Gudipati, **CPC-A**
Santosh Kumar Gupta, **CPC-A**
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Sara Schulte, **CPC-H-A**
Sarah Blake, **CPC-A**
Sarah Bobbitt, **CPC-A**
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Sarah Gage, **CPC-A**
Sarah Good, **CPC-A**
Sarah Grundeman, **CPC-A**
Sarah Harmon, **CPC-A**
Sarah Hatton, **CPC-A**
Sarah Stam, **CPC-A**
Saranya Shanmugasundaram, **CPC-A**
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Sarvesh Kumar Trivedi, **CPC-H-A**
Sasikumaran Gunasekaran, **CPC-A**
Satheesh Ponnayyan, **CPC-A**
Savitha Thomas, **CPC-A**
Scarlett Caldwell, **CPC-H-A**
Scott Kruse, **CPC-A**
Selvam Kuppan, **CPC-A**
Senthil Kumar Mani, **CPC-A**
September Lyons, **CPC-A**
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Sevvel Arumugam, **CPC-A**
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Shalini Tiwari, **CPC-A**
Shane Lawson, **CPC-H-A**
Shaneaqua Clayton, **CPC-A**
Shankar Thanikachalam, **CPC-A**
Shannon Gosnell, **CPC-A**
Shannon H Ennis, **CPC-A**
Shannon Wiebke, **CPC-A**
Shannon Williams, **CPC-H-A**
Shari Gill, **CPC-A**
Shari Moffat, **CPC-A**
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Sharlene Tuiteleleapaga-Stevens, **CPC-A**
Sharon Mossbrucker, **CPC-A**
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Shawn Reddick, **CPC-H-A**
Shawna Miller, **CPC-A**
Shawnda Hilliard, **CPC-A**
Shawnice Brown, **CPC-H-A**
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Shelita Cannon, **CPC-A**
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Shelly Taylor, **CPC-A**
Sheree Cyphers, **CPC-A**
Sheri Erickson, **CPC-A**
Sheri Lynn Pitcock, **CPC-A**
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Sherise Sandlin, **CPC-H-A**
Sherlyn Miranda, **CPC-A**
Sherri Thourot, **CPC-A**
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Sherry Jenkins, **CPC-A**
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Shoy Antony Pulikottil, **CPC-H-A**
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Sirisha Andavarapu, **CPC-A**
Sivasenan Varutharaj, **CPC-A**
Sophie N Callihan, CPC-A, **CPC-H-A**
Soumyamol Thomas, **CPC-A**
Sowmiya Selvaraj, **CPC-A**
Sowmya Purusothaman, **CPC-A**
Sree Saila Ganji, **CPC-A**
Sridhar Illendula, **CPC-A**
Sridhar Sampath, **CPC-A**
Srinivasa Rao Dusanapudi, **CPC-A**
Stacey Everett Adcock, **CPC-A**
Stacie Wilson, **CPC-A**
Stacy Renee Hardy, **CPC-A**
Stalin Pamu, **CPC-A**
Stefanie Capite, **CPC-A**
Stephanie Wells, **CPC-H-A**
Stephanie Desilets, **CPC-A**
Stephanie Dillman, **CPC-A**
Stephanie Gray Fulton, **CPC-A**
Stephanie Haney, **CPC-A**
Stephanie Hunt, **CPC-A**
Stephanie Kappos, **CPC-A**
Stephanie Mathis, **CPC-A**
Stephanie Peters, **CPC-A**
Stephanie Walker, **CPC-A**
Stephen Jackson, **CPC-A**
Sue Detherage, **CPC-A**
sumithu Jo Vellolil, **CPC-A**
Sunanda Koya, **CPC-A**
Sung-ea Lloyd, **CPC-A**
Sunil Kumar Komma Reddy, **CPC-A**
Suresh Seshan, **CPC-A**
Suresh Venkatesan, **CPC-A**
Sureshbabu Mariappan, **CPC-A**
Suryakala N Jaikishen, **CPC-A**
Susan Dianne Shuler, **CPC-A**
Susan Ellis, **CPC-A**
Susan Joy Mathew, **CPC-A**
Susan Krueger, **CPC-A**
Susan Lynn Ramage, **CPC-A**
Susan Marie Jordan, **CPC-A**
Susan Michelle Crook, **CPC-A**
Susan Murray, **CPC-A**
Susan Ping, **CPC-A**
Susan Smith, **CPC-A**
Susan Theresa Hill, **CPC-A**
Susan Victoria Skidmore, **CPC-A**
Susan Vuong, **CPC-A**
Sushil Kumar Maurya, **CPC-A**
Susmitha Yandrapu, **CPC-A**
Suzanne Fee, **CPC-A**
Suzanne Gallant, **CPC-A**
Suzanne Ventrella, **CPC-A**
Suzanne Waggaman, **CPC-H-A**
Suzy Thankachan, **CPC-A**
Swetha Vellampalli, **CPC-H-A**
Sydney Roberts, **CPC-A**
Tabe R Spell, **CPC-A**
Tamala Rae Flores, **CPC-A**
Tamara Ellison, **CPC-A**
Tameesha Renee Holloway, **CPC-A**
Tameka M Hamilton, **CPC-A**
Tami Coughlin, **CPC-A**
Tamilarasi Tharmalingam, **CPC-H-A**
Tammi L Swan, **CPC-A**
Tammie Upshaw, **CPC-A**
Tammy Alton, **CPC-A**
Tammy Dunlap, **CPC-A**
Tammy Gustafson, **CPC-A**
Tammy Stephens, **CPC-A**
Tammy Sue Baker, **CPC-A**
Tanya Lee, **CPC-A**
Tara Kasturi, **CPC-A**
Tari Slayton, **CPC-A**
Tatiana Cornell, **CPC-A**
Teisa Lavaka, **CPC-A**
Teisha S Tucker, **CPC-A**
Tera Michelle Wittneber, **CPC-A**
Tereasa Thornhill, **CPC-A**
Teresa Delaney, **CPC-A**
Teresa Johnson, **CPC-A**
Teresalita Vega, **CPC-A**

NEWLY CREDENTIALED MEMBERS

Terri Boyle, **CPC-A**
Terri Case, **CPC-A**
Terri Lee Kelley, **CPC-P-A**
Terumi Nishiyama, CPC-A, **CPC-H-A**
Theresa Geister, **CPC-A**
Therese Kidd, **CPC-A**
Thomas J. Aricatt, **CPC-A**
Tiana Lynn Benway, **CPC-A**
Tierney Klecker, **CPC-H-A**
Tiffani Hines-Gonzales, **CPC-A**
Tiffany Noel McClary, **CPC-A**
Tiffany Rushing, **CPC-A**
Tiffiny Reed, **CPC-A**
Tijo Thomas, **CPC-A**
Tina Jones, **CPC-A**
Tina LaPointe, **CPC-A**
Tina Marie Pham, **CPC-A**
Tionna N Robinson, **CPC-A**
Tom Urban, **CPC-A**
Tonya Lynn Bryant, **CPC-A**
Tonya Wright, **CPC-A**
Traci Degrafenreid, **CPC-A**
Trinidad Borden, **CPC-A**
Troy L Thomas, **CPC-A**
Trudi Wood, **CPC-A**
Twanna Stevens, **CPC-A**
Tyler Tobler Abraham, **CPC-A**
UmaSankari Subramanian, **CPC-A**
Vaibhav Yelle, **CPC-A**
Valerie Gathers, **CPC-A**
Valerie Rivas, **CPC-A**
Vanessa N Garrett, **CPC-A**
Vanessa Ochoa, **CPC-A**
Varsha Vasanth, **CPC-A**
Velanganni Mary, **CPC-H-A**
Venkata Muni Chandra Kumar Sankatala, **CPC-A**
Venu Gopal Sridharan, **CPC-A**
Venugopal Rajendran, **CPC-A**
Veronica Sheree Harris, **CPC-A**
Vicky Murphy, **CPC-A**
Victoria Helton, **CPC-A**
Vijay Miriyala, **CPC-A**
Vikki Decaire, **CPC-A**
Violet Newman-Coyle, **CPC-H-A**
Viridiana Cecena, **CPC-A**
Vishal Kaushik, **CPC-A**
Vishnu Priya, **CPC-A**
Vishnupriya Garuwandala, **CPC-A**
Viswavani Rajkumar, **CPC-A**
Vivian Zambrano, **CPC-A**
Viviana Posada, **CPC-A**
Vorsu Sandhya, **CPC-A**
Waltraud Ross, **CPC-P-A**
Wanda Hensley, **CPC-A**
Wendi Schumacher, **CPC-A**
Whitney McMillan, **CPC-A**
Willandson Cabanes Sale, **CPC-A**
Xin Toth, **CPC-A**
Yavanarani Neelakandan, **CPC-A**
Ylang Andrea Asidao, **CPC-A**
Yogesh Kumar Belaramani, **CPC-A**
Yordanka Gonzalez, **CPC-A**
Yuen Yee, **CPC-A**
Yuk Ping Liu Lam, **CPC-A**
Yuling Zhang, **CPC-A**

Specialties

Adele Marie Davis French, CPC, **CUC**
Agnes L Jackson, **CPCO**, CPC-P, CPMA
Aimee R Miller, CPC, **CPB**
Aishia K Frazier, **CRHC**
Ajith Kumar Kantrapati, CPC, CPC-H, **CPMA**
Alice Ramos, CPC, **CPCO**
Allyssa M Kittle, CPC, **CPMA**
Amanda Jenkin, CPC-A, **CPCO**, **CPMA**
Amber Baumgardner, **CGIC**
Amber Price, **CPB**
Amy Phillips, CPC, **COSC**, CSFAC
Anca Ion, CPC, **CGIC**, COBGC
Andrea E Godfrey, CPC, **CPMA**
Andrea Montague, CPC, **CSFAC**
Angela D Hunt, CPC-H, **CEDC**
Angie Garrett Brown, CPC, CPC-H, **CPMA**, CPC-I
Anita M Bennett, CPC, **CPCO**, CFPC
Bania Aguilera, CPC-A, **CPMA**
Beverlyjean K Jenkin, CPC, CPCO, CPMA, **CPPM**, CPC-I
Camie Bertagnolli, **CPB**
Candace M Jones, CPC, **CPMA**
Carla C Keller, CPC, **CEDC**
Carol Denton, **CPCO**
Carol Peacock, CPC, **CPB**
Chelsey Morrison, CPC, **CCVTC**
Cheryl Chatter, CPC, **CPCO**
Christina Michelle Cordes, CPC, **CCC**
Christine Reilly, **CPCD**
Claudine Rosson, CPC, **CPMA**, CPC-I, CEMC
Connie J Myers, CPC-H, **CEDC**
Connie Louise Nielsen, CPC, **CRHC**
Conrad Sinsay, CPC, CEMC, **CGIC**
Coriander Pulliam, CPC, **CPB**
Corrine A Sorge, CPC, **CCC**
Cynthia Araya, CPC, **CUC**
Cynthia Bishop, CPC, **CPMA**
Cynthia Padilla, **CHONC**
Cynthia Vanderpoest, CPC, **CPMA**, COSC
Dean James Leanch, CPC, CPB, **CPPM**
Deanna Eileen Lundquist, CPC, CPMA, **COSC**
DeAnna Rae Carter, CPC, CEDC, **CEMC**
Deborah Johnson, **CPCO**
Deborah Kushner, CPC, **CPPM**
Debra R Volcko, CPC, **COBGC**
Delicia Traylor, **CGSC**
Diane Daigle, CPC, **CPB**
Dominica Gorlin, CPC, **CPMA**
Donna J Mills, CPC, CPC-H, **CPMA**, CCC
Dr. Dana Levine-Gelber, CPC, **COBGC**
Dunia Hernandez, CPC, **CPMA**
Earnestine Weems, **CIRCC**
Elise Hummert, **CPMA**
Elizabeth Cron, CPC, **CPMA**
Ellen Montgomery, CPC, **CPB**, CPPM
Emily Dingee, CPC, **CCC**
Erin Elizabeth Alford, **COSC**
Gina Kelly, CPC, CPC-H, **CIRCC**
Gina Lola Marie, CPC, **CEDC**
Gloria C Court, CPC, **CANPC**
Greg Thorson, **CPPM**
Heather Beard, CPC, **CPB**, CEMC, CGIC
James Emch, **CIRCC**
Janet M Ortega, CPC, **CEMC**
Jason DiNovi, **CPMA**
Jeanne Wernsmann, **CPCO**
Jeff Sandquist, CPCO, **CCPC**
Jennifer Heath, **CPMA**
Jennifer L E DeWitte, CPC, CPC-P, **CPB**
Jennifer S Brady, CPC, **CEDC**
Jennifer Tobia, **CANPC**
Jennifer Yossof, **CANPC**
Jeremy Stewart, CPC, **CEMC**
Jo Ann Hardgrove, CPC, **CPCO**, CPMA
Joyce Talbert, CPC, **COBGC**
June Brown, **CHONC**
Karen Jung, **CPPM**
Karen Mitchell, **CCC**
Karen Moles, CPC, **CANPC**
Karyn Sutton, CPC, CPMA, **COSC**, CSFAC
Katelynn Whalen, **CIRCC**
Katherine Johnston, **COBGC**
Katherine Ugorec, CPC, **CPPM**
Kathleen M Skolnick, CPC, CPCO, CPMA, **CPPM**, CPC-I
Kathy Greene, CPC-A, **CEMC**
Katya Martinez, **CGIC**
Kay Mooney, **CPB**
Kelly Eccles, CPC, **CPPM**
Kelly Richins, **CPPM**
Kim L Christensen, **CPMA**
Kim Leonard, **CPPM**
Kimberly A Meehan, CMM, CPC, **CPMA**
Kimberly Hill Francisco, CPC, **CPMA**
Krista Poyer, CPC, **CPMA**
Kristie Beigh, CPC, **CEMC**
Kristina Lewis, CPC, **CFPC**
Lakesha L Brown, CPC, **CCC**
Lan Xu, CPC, **COSC**
Laura L Cummings, CPC, **COBGC**
Laura L Goodwin, CPC, **CGSC**
Laurie Campanelli, CPC, **CPMA**
Lawonna M Patrick, CPC, COSC, **CSFAC**
LeAnna R Hamilton, CPC, **CSFAC**
Leila Imbrogna, CPC, **CENTC**
Linda Jean Jackson, CPC, **COBGC**
Lisa Dunken, CPC, **CFPC**
Lisa J Edwards, CPC-A, **CANPC**
Lisha Rodriguez, **CPRC**
Lora Ann Marrs, CPC, **CPPM**
Loredana Finis, CPC, CPCO, **CPPM**
Lori LaClair, CPC-A, **CEMC**
Lori Prenzel, CPC, **CENTC**
Luz E Mendez, CPC-A, **CPB**
Lynn Fenelon, CPC, **COBGC**
Lynn Goin, **CFPC**
Lynne Y Gratton, **CPPM**
Mandy Thompson, CPC, **CPMA**
Margaret Mary Theiss, CPC, **CGIC**
Maria A Ferreira, CPC, **CPCO**, CPMA
Maria Boller, **CPB**
Maria Calcaterra, **CPCO**
Marilyn Kay Lawrence, CIRCC, **CCC**
Marlene M Anderson, CPC, **CPCO**, CPMA
Mary B O'Neill, CPC, CPC-H, **CEMC**
Mary C Albecker, CPC, **CPCO**, CPMA, CPPM
Mary Jungers, **CCVTC**
Mary M Moore, CPC, **CPMA**, CEMC
Meghan Ault, CPC, **CGIC**
Melanie Dias, CPC, CEMC, **CPRC**
Melissa Gibson, CCC, **CGIC**
Melissa Nichole Ashe, CPC-A, **CPMA**
Mercedes Izquierdo, **CPMA**
Meridith Fink, CPC, **CPMA**
Michelle Ann Richards, CPC, CPMA, **CPPM**
Mindy D Powell, CPC, CPMA, **CPPM**, CEMC
Mitzi N Robinett, CPC, **CEMC**
Monica A Lavergne Diaz, CPC, **CPB**
Monica Mitzenmacher Watson, CPC, **CPMA**
Monica Rodriguez, CPC, **CPB**
Nathan Jabara, CPC, **CPPM**
Nicole Kemp, **CEMC**
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Ysabel Lopez, CPC-A, **CPMA**
Yvonne Garay, **CGIC**

Magna Cum Laude

Aisha Cheong Hussain, **CPC**
Allison Clyne, **CIRCC**
Angelica Rubin, **CPC-A**
Ania Mairata, **CPC**
Ariet Figueroa, **CPC**
Bridget Elizabeth Brown, **CPC**
Candy Kahly, CPC-A, **CPC-H-A**
Carrie Miller, **CPC-A**
Cheryl Fassett, **CPC**
Christina Maranon-Schmidt, **CPC-A**
Cynthia Simpson, **CPC-H**, CPC-P, CIRCC
Danielle Aker, **CPC-A**
Ednis Almenares, **CPC**
Elisa Ferrogine, **CPC-A**
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Jennifer Jean Cox, CPC, **CEMC**
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Juliann Marts, **CPC**
Julius Q Merrifield, **CPC-H-A**
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Laura Hickenlooper Roberts, **CPC-H-A**
Maria Noel Gazzolo, **CPC**
Megan West, **CPC-A**
Myrna Martinez, **CPC-A**
Nikki I Bender, **CPC-H-A**
Nina Phipps, **CPC-A**
Pamela Elaine Gortman, CPC, **CPMA**
Patricia Browder, **CPC-A**
Polly A Willey, **CPC-H-A**
Raja Chinni, **CPC-A**
Richard Perez, **CPC-A**
Romy Rodriguez, **CPC-A**
Sabina Carinci, **CPC**
Sandra L Williams, **CPC**
Santosh Kumar K, **CPC-H-A**
Savitha Sivarama pillai, **CPC-A**
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So La Jang, CPC-A, **CPC-H-A**
Sonya Griffin, **CPC-A**
Sylvia Sandoval, **CPC-A**
Tamiko Jackson, **CPC**
Teri Baccus Hunter, **CPC-A**
Vaishnavi Retnaswami, **CPC**

A&P Quiz Answer

(from page 43)

The correct answer is D.

The four valves of the human heart are tricuspid, mitral, pulmonary, and aortic.

Robert Lewis, CPC-A

Assistant Project Manager at Health Revenue Assurance Associates (HRAA), Plantation, Fla.

I faced the same employment issues as all new coders do with no experience, except I was 59, and a "newbie."

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.

Five years ago, at the age of 58, I ended my telecommunications consulting practice of 20 years. It was time for a change. I had always wanted to work in the medical field, but I had no desire to work directly with patients. Coding interested me because the skill sets of a telecom analyst and coder are similar (although the "language" is different). Also, I didn't think my age would be as big of a concern as it could be in other occupations.

After a year of schooling for coding/billing, I faced the same employment issues as all new coders do with no experience, except I was 59, and a "newbie." Being a little creative, I talked my way into a contract job as a scheduler for other abstractors/reviewers during a three month Healthcare Effectiveness Data and Information Set project. Due to attrition, I was eventually allowed to review charts, as well. Armed with that experience, I eventually found employment coding encounters for a small practice.

I became certified at the age of 62; and I worked as a remote auditor for Orlando Health Group, reviewing inpatient and outpatient charts. I really enjoyed the daily challenges working with coding review (and correction) in a variety of specialties. Each chart was a new experience. It was rewarding, lucrative, flexible, and allowed me to work in an industry that's not as concerned with age as it is skill set.

Most recently, I have become assistant project manager at HRAA. My next goal is to obtain Certified Professional Medical Auditor (CPMA®) certification.

What is your involvement with your local AAPC chapter?

I attend local AAPC chapter meetings as regularly as possible. I am also considering running for an officer position in the next selection cycle.

What AAPC benefits do you like the most?

I enjoy the constant opportunity to update my skills by taking advantage of the education and training opportunities AAPC offers, such as the ICD-10 code training I'm currently taking online.

What has been your biggest challenge as a coder?

My biggest challenge as a coder (aside from reading illegible physician handwriting on paper charts) is keeping my electronic health record skills sharp. This is an ongoing process because of evolving software. Another challenge is staying abreast of medical advances for a variety of specialties.

How is your organization preparing for ICD-10?

My organization is offering in-house seminars and training to prepare the coding/auditing team for ICD-10 conversion.

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

I enjoy reviewing charts remotely, but also would enjoy interacting in the field, reviewing charts at provider locations.

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

I have two beautiful daughters, 24 and 19, and have been married to my wife, Andrea, for 26 years. My elder daughter is pursuing a master's at Johns Hopkins University and my younger daughter works for Barbie™: The Dream House Experience™ in Sunrise, Fla. I spend most of my spare time with my life-long passion, playing guitar. HBM

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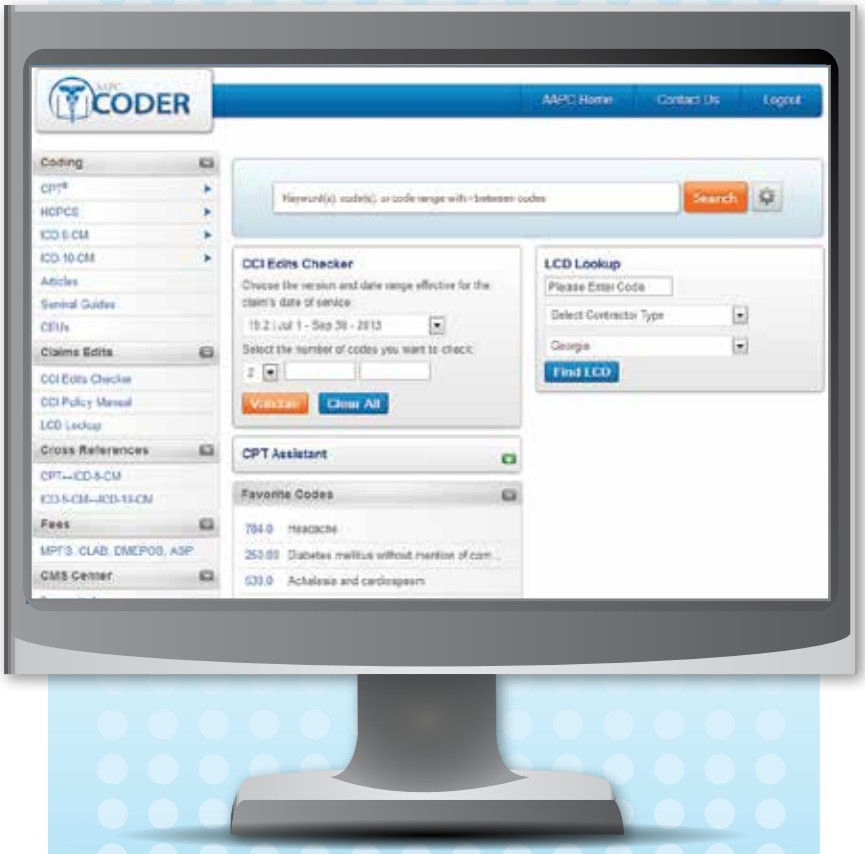

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