American Academy of Professional Coders
CODING edge
April 2008

Upholding a Higher Standard

Coder of the Year
Tammy L. Torres, CPC, CCP
Seattle

Networker of the Year
Keith Russell, CPC, CPC-H
Houston

Plus: Clubbing of Fingers and ROS • Global Period • Anaheim Conference Wrap Up • Chargemaster

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Features

On the Cover: Although in different parts of the country, Tammy L. Torres, CPC, CCP and Keith Russell, CPC, CPC-H, both praised for their communication skills, share the good news of being 2007's Coder and Networker of the Year. Cover Image by Damian Torres, Seattle, and Agapito Sanchez, manager of photography, Public affairs—Publications, Baylor College of Medicine, Houston.

In Every Issue

Education

People

Next Month

2007 Chapter of the Year

A Day in the Life of a Claim

Emergency Medical Coding

Targeting the AAPC Audience

The membership of AAPC, and subsequently the readership of *Coding Edge*, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

APPRENTICE	Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.
PROFESSIONAL	More sophisticated issues including code sequencing, modifier use, and new technologies.
EXPERT	Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

AAPC Code of Ethics

Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
- Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.
- Members shall respect and adhere to the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

Failure to adhere to these standards, as determined by AAPC, will result in the loss of credentials and membership with the American Academy of Professional Coders.

American Academy of Professional Coders

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

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We are the Voice of CPC®s

Congratulations to our 2007 Coder of the Year, Tammy Torres, from Seattle, and our 2007 Networker of the Year, Keith Russell, from Houston. Tammy is a member of the Lynwood, Wash. chapter and works for the University of Washington Physicians Group where she codes for ophthalmologists, otolaryngologists and others. She guided her physicians through a number of critical audits and established a Corporate Integrity Agreement in 2004.

Keith is employed at the Baylor College of Medicine as a Senior Compliance Analyst. He has been an officer in the Houston chapter for seven years, including Chapter President in 2007. For the past five years, Keith organized and hosted weekend classes six times per year prior to each examination proctored by his chapter. Almost all coders in the Houston area know Keith from one event or another.

A number of highly qualified CPC®s were nominated for these awards and it was difficult for our National Advisory Board to select the winners. All those nominated should feel honored to have been involved in the process.

Recently, the AAPC joined with the American Medical Association (AMA), the Blue Cross/Blue Shield Association, the American Clinical Laboratory Association (ACLA) and others to meet with staff from the Health and Human Services department (HHS) to discuss approximately $40 million requested in the next federal budget to begin ICD-10-CM implementation efforts. ICD-10-CM contains over 120,000 codes and is a major expansion of the 13,500 ICD-9-CM diagnosis codes. Implementation requires significant changes to all coding literature and software, and requires large educational efforts for coders.

A date has not been set by the government for ICD-10-CM implementation. However, some legislative proposals suggest an October, 2010 implementation date. HHS personnel indicated timelines are still under discussion. Along with the aforementioned groups, the AAPC recommends implementation of ICD-10-CM be delayed until after the adoption of 5010 standards, which are essentially an update of current HIPAA standards. These standards may be years away from adoption. Our team addressed these significant other issues for HHS to take into consideration:

- ICD-10 in other countries covers only inpatient codes, not outpatient
- Canada has found ICD-10 for outpatient care too expensive for compliance
- The transition to 15 Medicare Administrative Contractors (MACs) is massive and another significant transition such as ICD-10-CM implementation at or near the same time may complicate and frustrate health care providers and payers
- Careful planning of crosswalks from ICD-9-CM to ICD-10-CM is needed, and should be complete before implementation

The AAPC is assisting other major groups to push back the required implementation of ICD-10-CM for many good reasons. There will be a day when it comes and we must be fully prepared. The AAPC is developing a curriculum to teach ICD-10-CM. We plan to do everything we can to ensure our CPC®s are ready when the implementation comes.

The AAPC is working to ensure our credential is even more important when ICD-10-CM is implemented. For example, the credential is now legally a registered trademark bearing the ® symbol. This reinforces its place as the most respected, prominent, and useful coding credential. We'll continue to work with you to assure you're up-to-date on ICD-10-CM, and smooth the transition for your providers, employees and your profession.

Sincerely,

Reed E. Pew
CEO and President

R-E-S-P-E-C-T

Lately, the word respect has been on my mind quite a bit. If you are my age, you might remember the song Aretha Franklin sang back in the 60s titled "Respect" with the lyrics, "R-E-S-P-E-C-T, find out what it means to me." Respect is a word that we hear often. To most of us respect is another term for being polite. The scope of respect is far broader than the mere concept of politeness—it's one of the building blocks upon which all relationships are founded.

Have you ever been the subject of disrespect in the workplace? Most of us have at one time or another in our careers. What about the supervisor or manager who reprimands another employee in front of others to humiliate that person? It shows a lack of respect for that employee as well as everyone that witnesses the humiliation including the manager.

For example, let's say Mary was recently promoted into a coding manager position, and had the enormous task of reviewing all the coder's work from the previous day among many other duties. Mary was overwhelmed in her new job and felt her administrator, Joanna, did not give her a well-defined sense of direction. She was having trouble adjusting since her promotion. She asked for help with the piles of paperwork many times, but Joanna never had enough time to work with Mary. Mary missed some very serious coding mistakes while reviewing the staff's work. Joanna discovered these mistakes during a quarterly coding review. Joanna was very unhappy with Mary's job performance and decided to make an example of her, which she felt would improve Mary's performance.

During the weekly staff meeting, which included the physicians and coding staff (who report to Mary), Joanna proceeded to reprimand Mary for her poor job of detecting errors and disciplined her in front of the physicians and staff. Mary was humiliated and devastated that her credibility was destroyed in front of her colleagues. The next morning, Mary resigned. She felt she would never recover her credibility that was destroyed in one sweeping moment in the staff meeting. She told Joanna she didn't have a problem with being reprimanded for her mistakes, but felt it should have been done privately. Because of the public lashing, she felt she could never respect her boss again.

Did the administrator handle the situation correctly? How should it have been handled? Because you made a mistake doesn't mean the administrator doesn't respect you, does it? How the administrator handled the interaction with Mary is very important as to how the situation is perceived. By reprimanding Mary in an inappropriate setting, the administrator said to the group "I do not respect any of you because I put everyone in this uncomfortable situation." If a manager or administrator speaks with you about a situation or problem in front of your colleagues to criticize you, that would indicate a sign of disrespect for your right to a private conversation in relation to the matter at hand. How we handle a sensitive situation says quite a lot about how we take other's feelings into consideration.

What does this have to do with any of us? We all deserve respect from our colleagues, employees, and/or peers. Respect should be

Although honesty and trustworthiness are two key ways to earn respect from others, there are many more necessary traits.

valued and earned. According to Webster's Dictionary, respect is a "high or special regard." For a person to gain respect, he or she must be held in high regard by another. Although honesty and trustworthiness are two key ways to earn respect from others, there are many more necessary traits. Those who easily earn respect have better personal and professional relationships than those who don't respect others or earn the respect of others.

Earning respect at work involves understanding the tasks, completing projects in a timely manner, fulfilling all obligations, and being trustworthy. One key element of respect is learning how to listen. People who develop good listening skills and communicate effectively with co-workers can grow and excel. If the administrator would have listened to Mary when she needed help, her mistakes could have been avoided and the reprimanding unnecessary.

Trust is a really important skill in earning respect. One of easiest ways to earn respect and trust in the workplace is to "stay off the gossip line." It can be fun and amusing to visit the gossip line; however, it can be harmful and difficult for others to trust you if they believe you are spreading gossip. One key element in earning respect is to follow the Golden Rule, "Do unto others as you would have them do to you." To apply it, you'd imagine yourself in the exact place of the other person on the receiving end of the action. To gain and give respect we must first respect ourselves which can be a difficult trait to master. Learning how to earn respect can benefit both our professional and personal lives, and in turn teaches us to respect others. Here are a few tips to gain and give respect.

Respect is:

- Listening without interrupting
- Taking other's feelings into consideration
- Keeping an open mind
- Agreeing to disagree
- Trying to understand another's viewpoint
- Loving yourself
- Trust and honesty
- Giving each other space
- Nonviolence
- Direct communication
- Building a person up instead of tearing them down
- Friendship
- Not pressuring the other person

R-E-S-P-E-C-T
Find out what it means to me
R-E-S-P-E-C-T

Until next month …

Respectfully yours,

Deborah Grider,
CPC, CPC-E/M, CPC-H, CPC-P, CCS-P
National Advisory Board President

HCPCS Level II: The Stone Soup of Coding

Avoid confusion by knowing where HCPCS comes from

by Brad Ericson, CPC, CPC-ORTHO

There are few measures of the coding community's breadth as wide as the Healthcare Common Procedure Coding System (HCPCS) Level II codes, one of the official HIPAA code sets. Publicly compiled from a number of different sources and used in a number of venues, the HCPCS Level II codes grow in importance and usefulness.

While the changes in HCPCS Level II alphanumeric codes for 2008 aren't as voluminous as in past years, they are extensive and purposeful. More than 200 codes were deleted and nearly 250 codes added since the 2007 set was introduced. Several new modifiers are added to the system this year with some going into effect later this year, and many can be used with CPT® (HCPCS Level I) codes.

The Stone Soup of Coding

The average apprentice coder finds the jumbled pantry of procedures, services and supplies in HCPCS Level II confusing and bothersome. But understanding where they come from and why they exist will help you use them properly.

HCPCS Level II codes are compiled by the CMS HCPCS Level II Workgroup through what is largely a public process. Unlike data-gathering ICD-9-CM codes, which are developed by the National Center for Health Statistics (NCHS), a division of the Centers for Disease Control (CDC), and CPT® codes, which are developed, owned and copyrighted by the American Medical Association (AMA), the HCPCS Level II code set is meant to be a public repository for codes not appropriate for the other two core code sets. It incorporates codes and nomenclature for everything from payment systems like Medicaid, Outpatient Prospective Payment System (OPPS), ambulance, durable medical equipment, day-to-day supplies, drugs, prosthetics, glasses, orthotics, hearing aids, hospital outpatient services, dental checkups, daycare, and surgery. Toss into this boiling pot HCPCS' additional roles as a testing ground for possible CPT® codes, as a federal means for tracking demonstration projects, and as a platform for the new Physician Quality Reporting Initiative (PQRI), and it becomes the Stone Soup of the core code sets.

And like the Stone Soup of folklore, HCPCS Level II proves one of the most useful of the coding sets for most specialties, bringing several members and services of the health care community together. Nearly every specialty draws a bowl of soup from HCPCS Level II.

Making the Soup

Some HCPCS codes are provided by organized outside entities developing them for specific audiences. The American Dental Association (ADA) adapts their copyrighted Current Dental Terminology (CDT) codes for the D dental codes. Blue Cross and Blue Shield develop and provide the S services and procedure codes of which mirror CPT® codes.

Since the demise of the state-specific and contradictory HCPCS Level III local codes in 2003, state Medicaid agencies apply for national HCPCS codes representing the services they provide. This assures a national coding standard for services usually found in the H and T sections, which include Medicaid, substance abuse, and counseling codes.

Other codes must travel a longer and more hazardous path to creation or change. At the beginning of

CMS' delicate dance is properly providing the best coding for Medicare, Medicaid, and commercial payers; serving beneficiaries fairly; simplifying coding and complementing federal, state, and commercial payer budgets.

the year, the CMS workgroup receives requests for additions and changes from manufacturers, coders, special interest groups and professional associations. The workgroup's delicate dance is how to properly provide the best coding for Medicare, Medicaid and commercial payers; serve beneficiaries fairly; ease coding and complement the federal, state and commercial payer budgets impacted by the codes.

External requests for codes and changes go through two tiers of consideration:

1. Does the item belong in the HCPCS Level II code set?
2. Which HCPCS code should be used?

Considerations for the first tier include a product's status with the Food and Drug Administration (FDA), the request's appropriateness for HCPCS as opposed to another code set and a national need for the code or change. Considerations for the second tier include existing codes to modify or augment with an additional code, sections in which to place the code, and upcoming projects. The CMS workgroup makes decisions and prepares for public meetings held in late spring.

CMS also makes preliminary recommendations regarding the applicable Medicare payment category and methodology that would be used to set a payment amount for the items. The preliminary coding and payment recommendations are posted on the HCPCS website at www.cms.hhs.gov/medhcpcsgeninfo/01_overview.asp as part of the public meeting agendas. The meetings cover drugs and biologicals, orthotics and prosthetics, durable medical equipment, supplies, and other possible codes. Presentations are evaluated by representatives from CMS, the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC), and other interested parties.

Proponents for new or changes to existing codes make their arguments, present data, and demonstrate items for which codes are being considered. Presenters range from a patient who has invented a new device to major corporations. Each receives an equal hearing followed by questions.

Following the public meetings, the workgroup reconvenes and considers all the input. CMS also reconsiders its Medicare payment recommendations. Payment determinations for non-Medicare insurers, (e.g., state Medicaid agencies or private insurers) are made by the individual state or insurer.

Internal changes are requested by CMS workgroups like the OPPS organization, which maintains the dynamic C codes for ASC and OPPS pass-through payments. The addendum B of OPPS often includes codes either not provided on the CMS HCPCS website or before they are posted in support of the Outpatient Code Editor. Addendum B can be found at www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp.

Now Where IS that Code?

Once a code is approved, it's announced via transmittals, press releases, and through CMS' HCPCS Web pages. Your payers may post changes on their Web sites, and data can be purchased through the federal National Technical Information Service (NTIS) and health care data providers and publishers.

Most changes since the previous posting of the whole data set are posted free annually. The file, which incorporates four years of changes to the code set, can be found at www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage in early November. Most HCPCS Level II code books, because of the budgetary realities of publishing, use this annual file as their basis. HCPCS Level II codes, because of their use in so many situations, can change throughout the year. Quarterly changes are posted at www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage.

Changes to particular codes and modifiers, especially those in the C and G sections, can happen any time. Sometimes, effective dates are a quarter or more away, and other times, they're retroactive and can disrupt an existing claim. It's important to remain current with the CMS Web site to stay on top of this dynamic set.

So Where Can I Find Help?

Besides your colleagues, AAPC's forums, your local payers and intermediaries and CMS itself, CMS recommends the American Hospital Association (AHA) to answer written questions submitted at this Web site: www.ahacentraloffice.org/ahacentraloffice/html/coding_advice/hcpcs/index.html.

Should you have questions about whether codes are covered by SADMERC or reimbursement amounts for a covered drug or DME item, go to this site: www.palmettogba.com.

Brad Ericson, CPC, CPC-ORTHO, is director of publications at the AAPC and may love HCPCS Level II codes a little too much.

bulletin board

Call For Writers!

Do you consider yourself an expert on a particular subject pertaining to medical coding or billing? Share your expertise with the rest of us! For an opportunity to become a published author in Coding Edge, the first step is to submit your ideas for articles to LettersToTheEditor@aapc.com. What are you waiting for?

"Spring" to Your Chapter in May

Everybody's attending local chapter meetings, especially in May since that'll be "Support your Local Chapter Month." There'll be contests, prizes and giveaways, so watch for more information to come from AAPC. Don't miss out on the fun!

How is Your Chapter Celebrating?

Let us know how your chapter is observing Spring to Your Chapter. Are you having picnics, making posters, donating time to a charity or cause? Tell us about how you make your chapter fun, and send pictures. We'd love to share your spring chapter events in Kudos.

Have a job that pays for CEUs?

Does your employer pay for your CEUs? If so, we'd love to here about it. Send and email telling how your employer helps you obtain CEUs to:

letterstotheeditor@aapc.com

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As you come across unusual or confounding operative notes, decode them and e-mail copies to us at extreme-coding@aapc.com or by mail to Extreme Coding AAPC, P.O. Box 704004, Salt Lake City, Utah, 84170. We will consider them for inclusion in this regular feature.

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true CPC BLUE

"Thank you for calling AAPC. This is Lindsey!"

Customer Service Department Head

Meet the AAPC Staff

Lindsey Archibald

I am sure many of you have heard me say this familiar greeting to you. I have been in the Service Center Department since it was started in July 2004 and in February 2007, I became the department manager.

Our mission in the Service Center is to make sure that everyone is greeted by a friendly and courteous member of our team and that your questions are answered correctly and efficiently. We also answer all the emails that come into info@aapc.com. Sometimes we get more than 100 emails a day. The goal is to answer all calls and emails when they are received and with the correct information. In January, we took over 8,000 calls and answered many thousands of emails.

I have to hand it to my team. They are required to know and retain a lot of information regarding new protocol and reviewing the existing protocol. We are always learning how to better serve our members. To accomplish this, I created in-services on phone skills to help our company be more helpful and personable on the phone. I have also implemented a "Hot Topics List" to enhance communication between the many departments at AAPC.

I have been with the AAPC for almost seven years and within those seven years I have been in a few departments, including the Exam and Education Departments. I learned many things from being in these departments and feel like the information learned has helped me succeed in my current position.

I was married in June 2004 to a great man. He had two boys from his first marriage and together we became an instant family. I didn't feel like our family was complete and in July 2006 we added another boy to our family. Now feeling way outnumbered, I wouldn't trade motherhood or the experiences it has to offer.

I love being a part of the Service Center Department. I have a great team and I enjoy talking with and emailing our great members. The AAPC is truly a great place to work and to be a part of. Thank you for letting our team help and serve you. If you would like to contact me with any concerns or suggestions, please call or email me at lindsey.archibald@aapc.com. CE

Up Close and Personal

When you are not at work, what types of things do you enjoy doing?

I enjoy playing soccer, going on family trips, playing the competitive game of miniature golf and watching movies at home.

Spare time?!? I spend my spare time at home. My baby, Owen, is now 18 months old and I try to spend as much time with him since he is growing up so fast. Then I am also helping our other boys, Stephen (14) and Dallin (10) with their homework. Life never stops for a second as we are always doing something.

Letters to the Editor

Feed Your Chapter Without Being Spammed

Dear Editor,

After serving as both secretary and president for AAPC Local Chapters, I continue to receive complaints from members regarding the types of emails they receive from some of the local chapters or others affiliated with chapters.

Some private businesses obtain member email addresses and then use those emails addresses to "advertise" services or products from their own companies.

I made the mistake of creating the email group and "labeling" it with the chapter name. This allows all recipients to view all other recipient names and email addresses within the group and this is how businesses obtain our email lists.

However, some of you can learn from my mistake. Most email contact lists allow the user to form "groups." Once you form a group, "name" or "label" the group as "YOURSELF," and then you enter all email addresses as blind copy. When you distribute the email the only thing the recipients will see is that it is To: YOU and From: YOU. They will not view any other email on the distribution list. They will, however; still be able to respond to you if needed.

If only one officer such as the chapter secretary is responsible for sending out the meeting and workshop notices, this eliminates the need for others to send out any information that may be unfavorable or unwanted by chapter members.

Please be respectful and mindful of the fact that many of our members have email access through their employers and want to receive only pertinent information related to chapter business and AAPC notifications.

The local chapters are not here for members to use as their own form of free advertising. The AAPC allows businesses to advertise through their Marketing Department. If you have someone asking you to "advertise" for them through your chapter, please refer them to the AAPC rather than giving them access to our email addresses.

Thank you,

Trina Cuppett, CPC
Hickory, N.C.

Dear Trina,

Good point, Trina, and good advice. No one likes being exposed to unwanted emails, especially if they're coming from colleagues' friends.

Coding Edge

Ads Distract from *Coding Edge* Content

Dear Editor,

I like most of the design of the *Coding Edge* magazine but I would really like to go back to where the advertising is at the end of the magazine vs in the beginning and in-between articles. It really gets distracting when reading the magazine.

Sincerely,

Patty Kelly-Flis, CPC
Smithfield, Rhode Island

Dear Patty,

Thanks for your compliment about the design! We really appreciate the feedback and understand your frustration. The advertisements help us pay for the magazine and keep your membership fees reasonable. Advertisers prefer the ads be scattered throughout *Coding Edge* and sometimes their purchase is conditional on placement in a particular spot in the magazine. Unfortunately for some readers, advertising, which is meant to distract, does too good a job. We at *Coding Edge* will keep an eye on the layout to assure we keep articles together and easy-to-find.

Coding Edge

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

coding news

by Michelle Dick

CMS Pay Cuts Cap at 15.4 Percent

The Centers for Medicare and Medicaid Service (CMS) estimates a decline in Medicare payments to physicians of 10.6 percent below current levels to begin on July 1 and by 15.4 percent below current levels beginning Jan. 1, 2009. The cuts are due to an increase in services provided by physicians that exceeds growth targets, CMS says.

Congress is working on a Medicare package that would block the cuts.

Jeffrey Rich, director of the CMS Center for Medicare Management said, "The real issue is how Medicare can rapidly transform itself from a passive payer for services into an active purchaser of high-quality care by linking payment to the value of care provided." In a letter to the Medicare Payment Advisory Commission released on Feb. 29, he outlined steps CMS will take to improve quality and efficiency, including the following:

- The continuation and expansion of the Physician Quality Reporting Initiative (PQRI), which pays physicians 1.5 percent of their billed charges for reporting quality-of-care data
- Implementation of "structural measures," for purchasing and using electronic health record systems
- Boosting efforts to collect and share physicians' comparative costs data for greater efficiency
- Testing pilot programs, such as one that efficiently pays treating chronic conditions and another that develops medical homes for beneficiaries

You Can Suggest PQRI Quality Measures

PQRI is not going away, so here are some places to not only find the answers you seek about it, but to participate in the development process of what quality measures are being tracked.

CMS is offering you an opportunity to suggest PQRI measures for inclusion in the 2009 Medicare Physician Fee Schedule (MPFS).

To find more information on suggesting PQRI quality measures to be considered in 2009:

1. Go to www.cms.hhs.gov/PQRI.
2. Select the Measures/Codes tab on the left side of the page.
3. Scroll down to the Downloads section.
4. Select "Notice of 2009 Measure Suggestions."

Implementing PQRI and fretting about how you're going to track the data? CMS' PQRI Tool Kit includes a downloadable file containing Data Collection Worksheets for the 2008 PQRI quality measures. To access this file:

1. Go to www.cms.hhs.gov/PQRI.
2. Select the PQRI Tool Kit tab on the left side of the page.
3. Scroll down to the Downloads section.
4. Select "2008 PQRI Data Collection Worksheets."

You may have a lot of questions regarding PQRI. If so, CMS posts Frequently Asked Questions (FAQs) that may be of interest to your particular needs. To view these questions online:

1. Go to www.cms.hhs.gov/PQRI.
2. Scroll to the bottom of the page.
3. Select either the link "All 2008 PQRI FAQS" or "All 2008 Overview FAQS."

Responding to Detected Offenses

Instill Order When Government Investigators Knock at Your Door

by Julie E. Chicoine, JD, RN, CPC

Although a search warrant gives government agents the right to enter and "seize" documents identified in the warrant, it doesn't necessarily mean that a crime occurred.

Without a moment's notice, federal and state agency investigators can show up at a health care provider's office or a facility to investigate suspected fraud. Under such circumstances, clinicians, business managers and coding staff members of physician practices, hospitals, or other health care organizations are often caught off guard and chaos ensues. To avoid the upheaval of normal daily function and minimize risk, providers should have a mechanism in place to ensure an orderly response to government investigations. To eliminate panic when an auditor comes knocking at your door, consider these principles for developing an effective response to external investigations.

The Investigators

Federal investigators are individuals from the Department of Health and Human Services (HHS), Office of Inspector General (OIG), the United States Department of Justice (DOJ) or the Federal Bureau of Investigation (FBI). Regardless of which agency's personnel presents at your door, it's important to verify their credentials. Ask for photo identification and make a copy for future reference. It's also helpful to obtain each investigator's complete name, title, agency, business address, and telephone number. You can obtain this information from the investigator's business card. This information helps the provider ascertain which federal or state agencies are involved and verify what roles are represented (e.g., auditor, attorney or agent) on the team. Such information is helpful when contacting external legal counsel (which should be done as soon as possible) and provides an overview of the situation.

On some occasions, more than one agency is involved in the investigation. If this is the case, providers should verify which government investigator and agency is in charge and who is serving as the primary point of contact for ongoing communication and document production.

The Search Warrant

It's not unusual for an investigator to have a search warrant. Although a search warrant gives government agents the right to enter and "seize" documents identified in the warrant, it doesn't necessarily mean that a crime occurred. Nonetheless, providers should ask the investigators to wait until legal counsel can be present to facilitate the investigation. In most cases, government investigators are flexible and agree to the slight delay. However, if such an option is not available, the provider should ask for the search warrant to make a copy of for further reference, as this document sheds light on the focus of the government's investigation and helps facilitate your legal counsel's defense of the matter.

During review of the search warrant, providers should check the physical locations where the investigators are permitted to search and what documents they can legally seize. Don't allow investigators to expand the search beyond those parameters. Unless a provider consents, investigators can't search rooms or ask for documents that aren't included in the search warrant. In addition to patient medical records, typical documents sought include: explanation of benefits (EOB), payer correspondence, remittance advice, emails and office policies.

Document production can be an enormous task. Under the best circumstances, providers should try to organize all of the documents to be copied into one room to limit the opportunity for the investigators to expand the scope of the search. Such an approach also minimizes disruption of business operations. Providers should designate an employee to make a detailed list of all documents reviewed and copied by the investigators (including disks and hard drives) and to take notes during the search, including identifying areas searched, investigators' comments, questions, and instructions. If the scope and extent of the search is significant, providers can and should request an ongoing schedule of document production over a mutually agreed-upon timeframe.

Providers should consider whether privileges exist for medical records and computer access. Evidentiary privileges that may be implicated include: attorney/

Don't allow investigators to expand the search beyond the physical locations where they are permitted to search and what documents they can legally seize according to the search warrant.

client privilege, attorney work product, medical staff peer review and mental health/substance abuse treatment record privileges. These issues should be addressed by legal counsel.

Finally, at no time should providers change, move, alter, destroy, or attempt to correct any documents subject to the investigation including paper, tape and electronic records. Doing so can lead to criminal liability. Any routine record destruction in accordance to office policy and procedure should be suspended until further notice.

The Search Process

Having government investigators in one's facility is disruptive. Providers should send staff members home immediately if they aren't directly involved in the search response operation and cancel any remaining appointments for the day.

Investigators may try to interview staff members while they are carrying out the search process. Remaining staff members should be instructed to be courteous and to cooperate with investigators to facilitate document production, but should not volunteer any additional information, as anything said during this process can be used in subsequent proceedings. Investigators can't coerce or intimidate employees to agree to an interview. Any employee, administrator or clinician interviews should take place with legal counsel present. If employees are interviewed, they should be instructed to tell the truth, but to stick to factual statements only and avoid anecdotal perceptions or speculation. If an employee can't recall specific events or does not know the answer to a question, he or she should say so. If any interviews occur, the provider's administrative representatives should take complete notes of what took place, including questions asked and answers provided.

After the Dust Settles

After the investigators leave, the provider, in coordination with legal counsel, should evaluate the factors that lead to the investigation. Such factors include a determination of the following:

- How the problem was identified
- Duration of the problem
- Specific cause of the problem (e.g., Medicare rule change)
- Whether any employees had prior knowledge of the problem
- Whether any patients were harmed by the misconduct

Providers should also stop all billing activity associated with the problem; take steps to calculate the financial impact, and decide whether there are disclosure obligations to other government and commercial payers.

An ad-hoc team that includes the provider's legal counsel should be established to guide the provider through the investigation and disseminate the appropriate information to additional parties as necessary.

Finally, organizations and individual health care providers should take a proactive approach by developing a policy and procedure for responding to government investigations so that all the steps in the process are delineated and essential contact persons (administration, compliance officer, legal counsel) are identified.

Resources

Additional information is available at the following Web sites:

www.oig.hhs.gov -This Web site contains information, including fraud alerts, bulletins, compliance guidance materials and disclosure information.

www.doj.gov -This Web site contains information including legal cases, litigation documents, and the U.S. Attorney's Manual.

Julie Chicoine, JD, RN, CPC, is an attorney, registered nurse and certified professional coder with several years of health care legal and regulatory experience. She serves as the compliance director for The Ohio State University Medical Center.

Clubbing of Fingers and ROS

Here's What to do...

by Nancy Reading
RN, BS, CPC, CPC-I

A member recently inquired, "Where can I safely count clubbing of the fingers on physical examination?" This question begs an issue that faces coders every day. We think we know the answer because that's how we always do it, or that is how we were trained. Better yet, I constantly get hit with the notion, "I thought I knew what that meant until someone asked me."

Clubbing of the fingers is found on physical examination of the distal phalanx. According to Robert A. Schwartz MPH, MD, the definition of clubbing is best described as:

"The profile of the distal digit is viewed. The angle made by the proximal nail fold and nail plate (Lovibond angle) typically is less than or equal to 160 degrees. In clubbing, the angle flattens out and increases as the severity of the clubbing increases. If the angle is greater than 180 degrees, definitive clubbing exists. An angle between 160-180 degrees falls in a gray area and may indicate early stages of clubbing or a pseudoclubbing phenomenon."

This definition is the same in the *Manual of Orthopedic Terminology*, by Blauvelt and Nelson as it is in the *Bate's Guide to Physical Examination and History Taking*, by Bickley. The issue here lies in the etiology of the clubbing, which is attributed to an extremely wide variety of illnesses and pathophysiology.

According to Schwartz, Hippocrates first described clubbing in relation to hypoxia. Clubbing is associated with a wide variety of diseases such as (but not limited to) pulmonary, cardiovascular, neoplastic, infectious, hepatobiliary, mediastinal, endocrine, and gastrointestinal diseases. It can also occur as an idiopathic finding or be attributed to a dominant mendelian genetic trait.

Defining the Cause

The jury is out on the underlying cause or mechanism of clubbing. Theories vary widely, and although pathways differ, the end results are the same. Proposed mechanisms include circulating vasodilators, neural, genetic inheritance, hypoxia and platelet-derived growth factor. According to Schwartz, "Hypertrophic osteoarthropathy as a syndrome defined by chronic proliferative periostitis of the long bones, digital clubbing, and joint swelling," is also a consideration.

To further complicate the issue, the nail bed/fold is considered part of the integumentary system based on the embryogenic cell line from which it is derived. All tissues of the integument—including the nails—arise from the ectoderm and some mesoderm during embryonic development.

The 1995 evaluation and management (E/M) examination guidelines are exclusively based upon the number of body areas and organ systems examined and documented. These are generic and without further definition or granularity such as that found in the 1997 exam guidelines. Of interest also in the 1995 examination guidelines are the criteria for a comprehensive examination:

Comprehensive: A general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).—A general multi-system exam of eight or more organ systems or a complete single system examination.

For the purpose of CPT® examination definitions, the following are considered body areas:

- Head, including the face
- Neck
- Chest, including the breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

EXPERT

For the purpose of CPT® examination definitions, the following are considered organ systems:

- Constitutional
- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Integumentary
- Musculoskeletal
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Counting coup here for clubbing would most conveniently fit in the "extremity" body area as a generic finding. However, for a comprehensive exam, it's best to look for an organ system to count this in "as appropriate," based on the encounter's presenting problem.

The 1997 guidelines read a little differently as the bullets are further defined within an organ system or body area. Below are several systems where clubbing is often counted:

Cardiovascular

- Palpation of heart (e.g., location, size, thrills)
- Auscultation of heart with notation of abnormal sounds and murmurs

Examination of the following:

- Carotid arteries (e.g., pulse amplitude, bruits)
- Abdominal aorta (e.g., size, bruits)
- Femoral arteries (e.g., pulse amplitude, bruits)
- Pedal pulses (e.g., pulse amplitude)
- Extremities for edema and/or varicosities

Musculoskeletal

- Examination of gait and station
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)

Examination of joints, bones and muscles of one or more of the following six areas:

- Head and neck
- Spine, ribs and pelvis
- Right upper extremity
- Left upper extremity
- Right lower extremity
- Left lower extremity

The examination of a given area includes the following:

- Inspection and/or palpation
- Assessment of range of motion
- Assessment of stability
- Assessment of muscle strength and tone

Skin

- Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
- Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)

Clubbing: Differential Diagnosis

Pulmonary	Cystic fibrosis Bronchiectasis Empyema Pulmonary abscess Tuberculosis, aspergillosis Asthma complicated by infections Pulmonary alveolar proteinosis Sarcoidosis Interstitial pneumonitis (lymphoid, chronic) Pulmonary fibrosis
Cardiovascular	Cyanotic congenital heart disease Congestive heart failure Myxoid tumor Subacute bacterial endocarditis Myxoma
Gastrointestinal	Inflammatory bowel disease Gardner syndrome Parasitosis Biliary cirrhosis or biliary atresia Chronic active hepatitis Celiac disease
Other	Diamond syndrome (myxedema, exophthalmos, clubbing) Thyrotoxicosis Hypervitaminosis A Malnutrition
Acquired, one or more digits	Aortic/subclavian aneurysm Brachial plexus injury Shoulder subluxation Trauma Maffucci's syndrome Gout Sarcoidosis Severe herpetic whitlow
Hereditary, familial (isolated)	Pachydermoperiostosis
Pseudoclubbing	Apert's syndrome Pfeiffer's syndrome Rubinstein-Taybi's syndrome

www.wrongdiagnosis.com/f/finger_clubbing/diagnosis.htm

Nancy Reading, RN, BS, CPC, CPC-I, Ms. Reading is the vice president of education at the AAPC, and the CEO of CedarEdge Medical Coding and Reimbursement. Her experience includes lead consultant for CES database development, clinical analyst for ClaimsManager System, and clinical editor for Ingenix for the medical dictionary for coders. She has also been a consultant for 3M, which is an independent consulting business with a national client base, and has educated staff and physicians on medical billing at the University of Utah. She currently sits on the third party relations committee for the Utah Medical Association.

This is not strictly a finding relegated to a specific organ system in the scheme of a wide variety of differential diagnoses and underlying etiologies.

The reader should note that the musculoskeletal system is the place to actually describe clubbing, while it is one of the systems prioritized low on the list of underlying etiologies.

With this information in mind, it seems prudent to first include clubbing where it best supports the presenting problem. However, when reading through the note, it might become evident what the physician is examining based on where it is found within the body of the note (for example, if she writes under cardiac, "RRR, no carotid bruits, no clubbing," then it can be counted under the Cardiovascular section under the 1995 guidelines). The final analysis is this is not strictly a finding relegated to a specific organ system in the scheme of a wide variety of differential diagnoses and underlying etiologies. Secondly, in the effort to give providers credit for all work they do, it can be related to a variety of problems or a general finding of the extremities or integumentary that is worthy of further investigation.

It may be common in the assessment and plan to see an electrocardiogram (EKG) and chest x-ray to identify the most common causes of clubbing. A complete blood count (CBC), sedimentation rate, and chemistry panel are also often associated with this finding. In the event there is fever, a sputum smear, culture and sensitivity, and blood culture are also common.

General Reference

www.emedicine.com/derm/topic780.htm

chapter 4 the Embryology Atlas http://cwx.prenhall.com/bookbind/pubbooks/martini10/Chapter4/deluxe.html

www.wrongdiagnosis.com/f/finger_clubbing/diagnosis.htm

KUDOS!

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Several new chapters are helping coders in their communities by providing places to learn and talk about our profession. We are excited about their establishment and offer kudos to the following:

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Coding Pearls

For Skin Care Challenges

by Stephen C. Spain, MD, FAAFP, CPC

PROFESSIONAL

The surgical treatment of common skin lesions is an important source of revenue for most family practice offices. Because skin treatment coding is complex, it's important for a coder to understand the different procedures and the common skin lesions their providers treat. Familiarize yourself with the following skin treatment services and supporting codes to help you select the proper CPT® code(s) and modifiers for correct billing and maximum reimbursement in a family practice.

Surgical Package Guidelines

The CPT® surgical package definition is found in the forward of the CPT® Surgery Section. As outlined in the definition, the skin procedure codes include any pre-procedure preparation, as well as the required local or regional anesthesia. Routine follow-up care is also included as part of the surgical package. **Note**: Laceration repair is not billed separately for the closure of simple wounds created as a result of a minor surgical procedure on the skin.

If multiple separate procedures are performed on the skin, be sure to append modifier 59 to additional procedures. For example, if a physician performs a shave biopsy of a 0.5 cm mole on the arm at the same time 10 skin tags are removed, code 11300 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less* and *11200-59 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions—distinct procedural service.* When the same procedure is repeated multiple times, either modifier 51 *Multiple Procedures* or modifier 76 *Repeat procedure or service by same physician* may be appropriate. If a shave biopsy is preformed on three arm lesions, two of which are 1.1 cm in size, and the third 0.5 cm in size, code as 11302 *lesion diameter 1.1 to 2.0 cm*, 11302-76 and 11300-51.

E/M Services

When an evaluation and management (E/M) service is allowed in addition to the skin procedure, coding for the skin procedure is often misunderstood. A new patient presenting for a skin procedure could qualify for an E/M service if their condition requires a separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure. If the skin problem is addressed in addition to the patient's presenting problem, then an E/M code is appropriate for the presenting problem, whether dealing with a new or

When applying coding rules to skin condition treatments, it's important that the medical record give precise information about the condition treated. If the record is unclear, the door is opened for the coding staff to discuss the care and treatment with the provider.

established patient. However, if a patient returns solely for the treatment of a previously diagnosed skin condition, and no other service is documented, billing an E/M code is incorrect. When billing an E/M service and a skin procedure together, many payers require that modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or Other service* is appended to the E/M code. Check with your local carrier when using this modifier.

Laceration Repair

Three key components for coding laceration repair correctly are complexity, location, and length. The complexity of laceration repair is generally determined by the depth of the wound and the amount of repairing required to mend the deeper layers of the wound. Most wounds fall into the simple or intermediate category. Wounds that do not require layered closure are considered simple, and these wounds encompass the majority of repairs in family practice. An intermediate repair requires suture placement inside the wound to approximate tissue layers below the skin. This is necessary in wounds that are particularly deep or gaping. When deep sutures are placed, they do not communicate with the skin and are not removed.

Selecting the proper laceration repair code is dependent upon wound location, and is explained in the 12000 section of the CPT® Surgery section. In the family practice setting, usually only a single repair is made. However, if more than one wound is repaired, the sum of the wound's total length is reported with the appropriate repair code, and the coder should pay particular attention to the summation rules in the CPT® manual.

Routine cleaning and preparation of a repaired wound is included in the repair code. However, if a simple laceration requires extensive cleaning and debridement, the repair can raise to the intermediate level, per the CPT® guidelines. This 'extra effort' should be well documented in the record.

If laceration repair requires the use of excessive or unusual supplies, the necessary extra supplies should be well documented, and billed separately for supplies (for example, CPT® 99070 *Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)*, or another applicable code could be submitted. Reimbursement for supplies in this circumstance is usually made with appeal, and coverage for additional supplies varies among insurers.

Biopsy

In family practice, skin biopsies are generally a shave biopsy or a full thickness biopsy. A shave biopsy is a shallow scraping of the skin done with a sharp blade held nearly horizontal to the skin. The resulting skin defect is very shallow and is often treated with a chemical or electrocautery to control bleeding. In contrast, a full thickness biopsy involves cutting into the deeper layers of the skin. Usually, the resulting defect requires a suture or two for closure. This type of biopsy is often done with a scalpel or a special punch biopsy tool. A wedge or plug of the skin is removed and sent for pathology evaluation. Biopsies requiring suture closure are coded using either 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* or 11101 *Each separate/additional lesion (List separately in addition to code for primary procedure)* for the additional biopsies, and the shave biopsies would be coded with the CPT® 11300-11313 series of codes.

If a biopsy is part of another procedure, the biopsy code is not separately coded. For example, if a biopsy is part of a 1.1 cm neoplastic lesion excision on the forearm, only the excision code CPT® 11602 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm is billed.*

Incision and Drainage

Family practitioners frequently treat skin conditions that require skin incision and drainage of fluid (pus, blood, or serous fluid). These procedures are referred to as incision and drainage (I&D). I&D implies a sharp instrument (e.g., a scalpel blade) is used to open the skin and material is drained or removed. In most cases, the wound is irrigated and thoroughly cleaned before applying a dressing. Larger wounds may require the insertion and changing of packing daily, to allow the wound to drain and close before the skin edges heal over the wound cavity. The two codes covering most I&D services in family practice are CPT® 10060 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single* and 10061 *complicated or multiple*. Multiple lesions, or any lesion that requires progressive repacking in the office or the management of systemic antibiotic therapy, could be considered complicated. There are separate I&D codes in the CPT® Surgery Section for foreign bodies, hematomas, puncture aspiration, and pilonidal cysts.

Skin Tags

Skin tags, or dermatofibromas, are fleshy, pedunculated growths that can occur anywhere, but most often arise on the neck, axillae, or groin area. They are usually removed with electrodessication or with a scalpel or scissors. Frequently, local anesthesia is used for this procedure. Because skin tags generally occur in clusters, and are simple to remove, they are coded separately from the destruction of other types of skin lesions. The CPT® 11200 *Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions* code for skin tag removal includes the first 15 lesions removed. The CPT® 11201 *each additional 10 lesions (List separately in addition to code for primary procedure)* code is used for each additional 10 lesions. For example, if 25 lesions are removed, code both 11200 and 11201.

Destruction

Many skin lesions are recognized easily as requiring removal without needing a biopsy. Typically, this would include actinic keratoses (crusty areas of sun damaged skin), irritated seborrheic keratoses (a brownish, raised, benign skin growth), and warts. These lesions are often simply destroyed. Commonly, this is performed with cryotherapy (often using liquid nitrogen) or electrocautery (aka electrodessication). Often, keratoses and warts are multiple, and the precise count of treated lesions is necessary when selecting the correct codes.

If a simple laceration requires extensive cleaning and debridement, the repair can raise to the intermediate level, per the CPT® guidelines. This 'extra effort' should be well documented in the record.

Excision

Usually, moles and other skin lesions require complete removal, or excision. The proper code selection depends upon whether the lesion is benign or malignant, so coding often waits until the pathology report is available. Physicians usually document the lesion size, which may vary. Be sure your physician gives you the total size of the excision, including the margins of tissue removed plus the lesion width. This total size is used to determine the correct excision code. There are illustrations in the CPT® Surgery Section that explain this point.

In family practice, most lesion excisions involve simple repair, which is included in the excision code. However, if the repair is more complex, such as requiring a layered closure or moving adjacent tissue to cover the wound, a separate wound repair code may be applicable.

Communicate for Correct Coding

When applying coding rules to skin condition treatments, it's important that the medical record give precise information about the condition treated. If the record is unclear, the door is opened for the coding staff to discuss the care and treatment with the provider. This discussion is a valuable opportunity for the coder to explain the documentation essentials for proper coding and payment. Working together in this way, health care providers and coding professionals achieve their common goals of reducing audit liabilities and enhancing practice revenue. CE

Dr. Stephen Spain, MD, FAAFP, CPC, has been engaged in the full-time practice of family medicine for over 25 years. In 1998, he founded Doc-U-Chart, a practice management firm specializing in charting documentation. Dr. Spain can be reached at sspain@docuchart.com.

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Upholding a Hi

Coding depends on networking and building solid working relationships. Tammy Torres, 2007 Coder of the Year, and Keith Russell, 2007 Networker of the Year, are two individuals who serve as role models by actively teaching, networking, and promoting coding excellence for themselves and others.

The American Academy of Professional Coders' 2007 Coder of the Year and Networker of the Year awards are to raise professional coding standards and promote the skills needed to build a solid coding network through leadership and example. This award is an opportunity to acknowledge and thank members who exemplify the higher standards set by the AAPC. The award winners were selected with your nominations upon merit through volunteering, coding expertise, and networking skills that have forged long-lasting coding relationships.

by Michelle A. Dick, Senior Editor

igher Standard

Tammy Torres: 2007 Coder of the Year

"I knew I could rely upon her expertise completely. What more could a provider ask for?"
Elaine L Chuang, MD
University of Washington School of Medicine

Tammy L. Torres, CPC, CCP, is a revenue coding analyst at Virginia Mason Medical Center in Seattle, auditing physician services and educating providers in relation to Centers for Medicare and Medicaid Services' (CMS) coding and documentation guidelines. She supports the plastics and reconstructive surgery, general surgery, thoracic surgery, vascular surgery, and otolaryngology departments.

Her colleagues at Virginia Mason, where she has been for about a year, are enthusiastic when asked about Tammy. Dr. Thomas Bielhe says, "Her door is always open. She is easy and pleasant to work with and she 'knows her stuff.'"

She began her health care career 23 years ago, working front office in a dermatology practice. Although she had a bachelor's degree in accounting, she found herself ill-prepared and challenged by insurance billing and coding. She soon discovered a knowledgeable colleague who showed her the ropes. Over the years, she worked as a medical transcriptionist, ambulatory surgery scheduler, office manager, medical assistant and a surgical scrub tech.

For eight years, Tammy worked at the University of Washington Physicians Group, first as a professional fee coordinator, coding from operative reports of the neurosurgery, otolaryngology, plastics, vascular, and ophthalmology departments, and then as a corporate compliance analyst performing provider audits and developing educational presentations.

Praise for Tammy at "the U-Dub" is easy to find. Dr. James Kinyoun says, "She was always readily available, responded promptly, knew the answers to my questions or where to find the answers, and did as much of the work as possible for me or all of it herself when she was qualified to do so."

Others remember her dedication as well. "She will go the extra mile to explain explicitly to providers and staff what code should be used and why. Tammy educates providers with integrity to do the right coding even when there is a lot of resistance … She is a great communicator, educator and researcher and gains the respect from everyone she works with, Noreen Nowak, CPC, says. This is echoed by Dr. Neal Futran, who told us, "She taught all the physicians in our department the proper way to conduct our billing and reporting procedures as well as how to follow the rules in an unencumbered manner … Tammy had a way of making it as pleasant and as easy as possible."

Certification Enhanced Tammy's Career

Since becoming certified in 1999, numerous career-enhancing opportunities came Tammy's way. For example, she worked in the capacity of a compliance analyst, and currently presents "best practice" coding and docu-

Keeping current with coding updates and guideline changes is always a challenge. I also find explaining coding rationale to non-coders challenging.
— Tammy Torres

mentation materials at the Virginia Mason Medical Center Otology/Otolaryngology update conferences.

In fact, several colleagues describe Tammy as being a role model of dedication to the craft of coding while sharing her enthusiasm with others. "Tammy has the unique ability to inspire her coworkers to strive to excel as well," Cindy Johnston, CPC, CHC, CCP, U of W says.

Chapter Participation

There are three AAPC chapters within close proximity to Tammy's home and office. Even with her busy schedule, she's able to attend at least one monthly meeting. She enjoys networking with chapter members, mentoring new coders, and proctoring for the AAPC certification exams. She knows what a valuable resource our chapter members are when she needs help in coding complex operative cases.

Coding Challenges

Tammy says, "Keeping current with coding updates and guideline changes is always a challenge. I also find explaining coding rationale to non-coders challenging."

Because coders and physicians don't always agree on the way a chart should be coded and a sensitive situation can arise, she encourages coders to personally introduce themselves to providers from the get-go and to develop friendly working relationships with them. This helps to ensure that future discussions with the providers are productive, not adversarial, and, of course, coders should always have their supporting documentation at hand.

Beyond the Credentials

If Tammy wasn't busy being a CPC®, she'd like to be a physical therapist or a personal trainer. The body's mechanics intrigue her, and she feels helping others become physically active, improve their fitness level, health, and quality of life would be a noble service.

Tammy is an avid runner. She enjoys traveling with her husband and participating in outdoor activities such as cycling, snorkeling, hiking and snow shoeing.

Keith Russell: 2007 Networker of the Year

"I don't know anyone who does more to promote our profession than Keith."
Maureen Baker, CPC

Keith Russell, CPC, CPC-H is on Baylor College of Medicine's compliance team and conducting reviews of clinical faculty charts to determine compliance with documentation requirements. He provides focused education to ensure that the faculty members are confident in billing at the correct level. Keith has served as treasurer, president-elect and president for the local chapter. Keith earned a bachelor of science in secondary education from the University of Arizona.

His coding career began in the summer of 1993 while working as a financial counselor at the University of Texas Medical Branch (UTMB) in Galveston, Texas. At that time, Nancy Maguire, the first National Advisory Board President of the AAPC, was also working for UTMB and was teaching coding classes on Saturdays during the fall. Keith had no idea what coding was; however, he decided to try something new and attend her class. He absolutely loved it.

Keith says Nancy was very inspirational, became his mentor, and hired him as an auditor in January 1994. After three years, he became a senior associate with PriceWaterhouseCoopers as well as a coding and reimbursement specialist for Columbia HCA and the University of Texas Medical Branch. In August 1999, he took a coding supervisor position with Baylor College of Medicine in Houston. He worked there for five years before joining the compliance team as a senior compliance analyst.

Keith has had the opportunity to work with a lot of terrific people throughout his 14 coding years, including Joan Benham and Jeff Giusti. He works with Jeff at Baylor and with Joan putting on a chart auditing class as an AAPC vendor. He can't imagine a better career, as coding has allowed him to grow professionally and personally. He uses his experience to help other coders. Keith says "Along with my work at Baylor, I've enjoyed my time working with the local chapter. I've also had many opportunities to tutor and assist people in pursuing their own coding careers. I think the most rewarding thing is seeing them succeed as coders."

His fellow Texans agree. His work with the chapter, where he has been an officer for six years, is the first thing they mention. Terrie Trimble, CPC and Jeff Giusti, CPC, CPC-H wrote us, "Keith spends a lot of his free time helping other coders become certified. He teaches classes, organizes and hosts the certification testing in our area, invites speakers and organizes the annual symposium held in Galveston, Texas each year and much more. He is always available to answer coding questions. If you are a new coder in the Houston area, you probably have met Keith."

Keith Values His Credentials

"I can't imagine where I would be without my CPC® and CPC-H® credentials, he says." They have opened doors and opportunities and allowed him to work for many great companies. They have afforded him traveling opportunities throughout his career either for work or to attend AAPC national conventions.

I can't imagine where I would be without my CPC® and CPC-H® credentials.
– Keith Russell

Local Chapter Involvement

For the past six years Keith has served as treasurer, president-elect and president of the Houston Chapter. This year is the first year in a long time he's not served as an officer, but he remains active in assisting with proctoring the six exams the chapter puts on throughout the year. For the past five years, he's worked with the Galveston Chapter to put on a symposium on UTMB's Galveston campus. It has been a huge success and draws between 200 and 300 people each fall. Keith says, "I hope to continue to be involved in this as well as the exams and local chapter meetings for a long time."

Others hope so, too. "He takes every opportunity that he can to teach, to share and encourage and offers the chance for all of us to become better coders, and for that he deserves the title of Coders of the Year," Maureen Baker says. She remembers how Keith shared the positive changes at AAPC with the chapter following a meeting with CEO, Reed Pew, helping to foster a positive attitude with skeptical members. Last year, she remembers, he hurried to share what he learned at the AMA's CPT® Coding Symposium in Chicago with the chapter.

Coding Challenges

The biggest challenge for Keith as a coder is getting people who don't understand coding to realize that it isn't as simple as assigning a code. He said, "Many times the comment you hear is how difficult can it be to pick a code. However, people aren't aware that there are many factors to consider when selecting the correct code and that some coding can be very complex, i.e. interventional radiology."

Beyond the Credentials

If Keith wasn't a coder his dream job would be a professional golfer or working behind the scenes for a professional sports team.

In Keith's spare time he enjoys golfing, playing on the computer, and collecting sports cards. Keith and his wife like entertaining friends and family during holidays and special events such as the Super Bowl. They also have fun spending time with their dog, Ginger, going out to eat, watching movies and traveling.

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by Michael D. Miscoe, CPC, CHCC

Global Period:

Reporting Subsequent Inpatient E/M Services Following Surgery

EXPERT

At the recent AAPC National Conference in Anaheim, I was asked an excellent question during ad-hoc networking. The question was, "Is subsequent inpatient E/M services or discharge evaluations following surgery within the global period reportable? If so, what modifier is appropriate?"

As is the case with most coding questions, the answer is: it depends. The ability to report subsequent hospital care following surgery is conditional. Let's look at the scenarios that determine the conditional correct answers, and demonstrate the process for finding them.

To find the answer, you should do the following:

1. Consider who you are billing.
2. Determine if there is a statutory or contractual mandate to follow that carrier's policies.
3. Search the relevant statute, regulation, policy or contract as appropriate to determine the appropriate rule on the issue if a mandate exists.

In this case, the carrier is Medicare. As a result (whether the provider is participating), we start our research with the National Correct Coding Initiative Policy Manual (NCCIPM) and also check the interpretive guidance published by CMS for a more restrictive position relative to this specific issue. In this situation, we can omit a review of the Medicare statute or regulations as it is unlikely either reference directly addresses this specific issue.

The NCCIPM defines the Medical/Surgical package at Chapter 1, Section C. You can find it on the World Wide Web at: www.cms.hhs.gov/NationalCorrectCodInitEd/. The NCCIPM clearly indicates, "most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work." While this section addresses "procedures" considered as part of the post-procedure work, it fails to address the issue of post surgical evaluation and management services. Subsection D of Chapter I addresses evaluation and management (E/M) services, but only focuses on the E/M services performed "on the same date of service as a procedure with a global period of 000, 010, or 090." The following additional guidance is found:

> *If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global pay-*

ment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

NCCIPM, Chapter 1, § D at p. 11.

This section of the NCCIPM is missing the instruction for *subsequent* E/M services during the global period included in the reimbursement for the surgical procedure.

Chapters III-VIII (relating to the various types of surgical procedures) each address the global period with respect to E/M and replicate the instructions at Chapter I referenced above. Chapter XI addresses E/M services directly and also duplicates the instructions above. As a result, there isn't a restriction in the NCCIPM for reporting subsequent in-patient E/M services during the global surgical period.

Although no such restriction is apparent in the NCCIPM, before we leap with joy we need to check to see if there is a relevant rule for subsequent in-patient hospital care in CMS' interpretive guidance. You can find the Medicare reference controlling this issue in the Medicare Claims Processing Manual, Pub 100-4, by simply researching CMS' interpretive guidance via the internet at: www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage.

While some familiarity with the Manual system is helpful, the site does provide the capacity to search various Medicare manuals. In this case, Chapter 12 provides the information relevant to our issue.

A. CPT® Modifier "-24"—Unrelated Evaluation and Management Service by Same Physician During Postoperative Period

Carriers pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT® codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT® modifier "-24," and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the doctor is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.

Pub 100-4, Ch.12, §30.6.6 A

As is the case with most coding questions, the answer is: it depends. The ability to report subsequent hospital care following surgery is conditional.

As a result, when the physician/surgeon evaluates or provides subsequent care for a condition unrelated to the condition requiring surgery, the subsequent care in-patient E/M service may be reported with modifier 24. Since most of us are aware that the reimbursement for the surgical procedure includes the usual post surgical follow-up, this may not come as a surprise. Because there isn't a general prohibition of reporting E/M services on days subsequent to a surgical procedure (within the global period), CMS provides a specific restriction to subsequent in-patient E/M services during the hospital stay when the surgery is performed and the service is related to evaluation and management of a condition unrelated to the surgery.

Now with a clear understanding of subsequent in-patient E/M services, what about the discharge? Let's turn to the Medicare Claims Processing Manual again for instructions, specifically:

A. Subsequent Hospital Visit and Discharge Management on Same Day

Pay only the hospital discharge management code on the day of discharge (unless it is also the day of admission, in which case, the admission service and not the discharge management service is billed). Carriers do not pay both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. Instruct physicians that they may not bill for both a hospital visit and hospital discharge management for the same date of service.

Pub 100-4, Ch. 12 § 30.6.9.2 A

Note: §30.6.6 doesn't address the discharge at all, and §30.6.9.2 restricts admission and discharge to occur on the same day. Since the NCCIPM doesn't include a general prohibition for reporting a ***subsequent*** E/M service during the global period, there isn't a clear restriction for reporting the discharge service unless the discharge occurred either on the same day as the admission, or the same day as the surgical procedure.

While the analysis and answer is relevant to Medicare claims only, I am hopeful the analytical approach and answer can be used to help you develop your own answers related to global period issues.

Michael Miscoe, CPC, CHCC, a 1985 graduate of the United States Military Academy, is the president of Practice Masters, Inc., and a member of the National Advisory Board of the American Academy of Professional Coders. He has over 17 years billing experience and 11 years of consulting experience with a wide variety of health care provider specialties.

All Ears In Anaheim

Coders come to Disneyland to learn from the experts

by Brad Ericson, CPC, CPC-ORTHO

January's AAPC National Conference in Anaheim, Calif. treated more than 700 attendees to a new level of coding education, but it was the number of physicians who participated in the conference that really excited members.

"A quarter of our speakers at this conference were physicians, and several more attended than in the past," said Reed Pew, CEO of the AAPC. "That there were so many indicates the growing interest in and acceptance of professional coding by doctors."

The first of this year's two national conferences was held at the Disneyland Hotel and included a popular exhibitor hall, numerous general and break-out sessions, and a trip for attendees to Disneyland. The other 2008 AAPC national conference is scheduled on June 8-11 at the Gaylord Palms Resort in Orlando, Fla. Hot topics in Anaheim included the following:

- Evaluation and management (E/M) auditing
- ASC changes
- "Incident-to" issues
- Cardiovascular coding

Specialties also had a day at the conference with discussions of coding for interventional radiology, ophthalmology, general surgery and pediatrics. All changes to ICD-9-CM, HCPCS Level II, and CPT® codes, as well as a preview of ICD-10-CM were reviewed.

Some attendees participated in PMCC training and sat for AAPC exams including core certification and specialty. Window-shopping in the exhibitor hall and networking with colleagues and friends not seen since the last convention were also popular activities.

The following is an overview of some of the sessions presented at the conference, which brought presenters from all over the country.

Dissection, Blood and E/M

Jane Tuttle, CCS-P, CPC, walked her audience through E/M chart auditing, which helped prepare them for Stephanie Jones' "The Last Audit Frontier: Providers, Payers, and E/M Visits." Both presentations helped spell out the realities and need for E/M auditing, how to prepare, and what to learn from the results.

A session to help providers navigate the rules of consultations was presented by Susan Manning JD, RHIA, CPC, and Susan Petty RN, BSN, CPC. It provided a unique legal definition for the practice, and participants learned about the proper documentation of a consultation request and report.

Hugh Aaron, MHA, JD, CPC, CPC-H, helped clarify one of the most talked-about issues at the conference, "incident to" rules for providers and facilities. Billing for services of NPs and PAs is complicated, he explained,

with revenue and compliance implications that can hurt physician practices that aren't watchful of the rules.

Carrie Severson, BSN, CPC, CPC-H, conducted a popular session on the eye titled, "Holy Cow! Ophthalmology" that included a hands-on dissection of cow eyes. Attendees enjoyed the opportunity to not only match the actual physiology with codes, but discuss procedures and their coding as they peeled the eyeballs apart. During their discussion of procedures performed on the eyeball and surrounding muscles, participants talked about intraocular lens (IOL) and the new ICD-9-CM code for floppy iris syndrome.

Another eye-opening session, "Ophthalmology Coding—From A Scans to YAG" by Sue Vicchrilli, COT, OCS, thumbed alphabetically through ophthalmology terms and procedures and how to code them.

Cardiovascular Presentations Make Hearts Race

The difficult coding of catheterization was the subject for Terry Fletcher's "Heart Caths & Intervention for the Cardiology Coder" in which she discussed the vascular orders for this approach and service. A related presentation by David Zielske, MD, CPC-H, CCS, RCC, talked about interventional radiology and vascular interventions which dealt with catheter coding from the side of interventional radiology. "Dr. Z" walked his participants through several cases of increasing complexity and difficulties, helping them understand the proper mix of codes from the Surgery and Radiology chapters of CPT®.

One session looked at vascular surgery codes. Alan R. Koslow, MD, FACS, explained various peripheral artery graft codes. He also addressed the issue of performing an angiography during a peripheral bypass. His verbal detail and graphic photos helped many attendees understand the theory behind many of these bypasses.

Linda Eickmann, CPC, shot footage of a CABG and narrated the film during a session entitled "A Trip to the O.R."

It's Anaheim, Now for the Kids

Several coders brought home more than stuffed animals to their pediatric facility and colleagues. A well-attended session on pediatric coding issues by Eric Haugen, MD, helped coders identify the most accurate and fair codes for childrens' visits and treatments. Nurse practitioner Jennifer Hill drilled down into the coding issues of pediatric gastroenterology. Her presentation focused on the gastroenterology cases seen in children as well as how best to reimburse for the NPs in the office.

Sheri Poe Bernard, CPC, CPC-H, CPC-P, discussed diabetes affecting children and adults in her presentation, "Understanding Diabetes." She provided a comprehensive explanation of types, etiologies, and coding of this medley of complicated and common diagnoses.

Dealing with the Basics

Presentations on the latest in the HCPCS Level II, ICD-9-CM, and ICD-10-CM code sets drew great interest as did Suzan Berman-Hvizdash's program on teaching physician guidelines. This session emphasized necessary guidelines and the methods of training physicians for proper documentation that meets compliance and reimbursement needs. CE

For more information about this conference and the upcoming session in Orlando, please see www.aapc.com.

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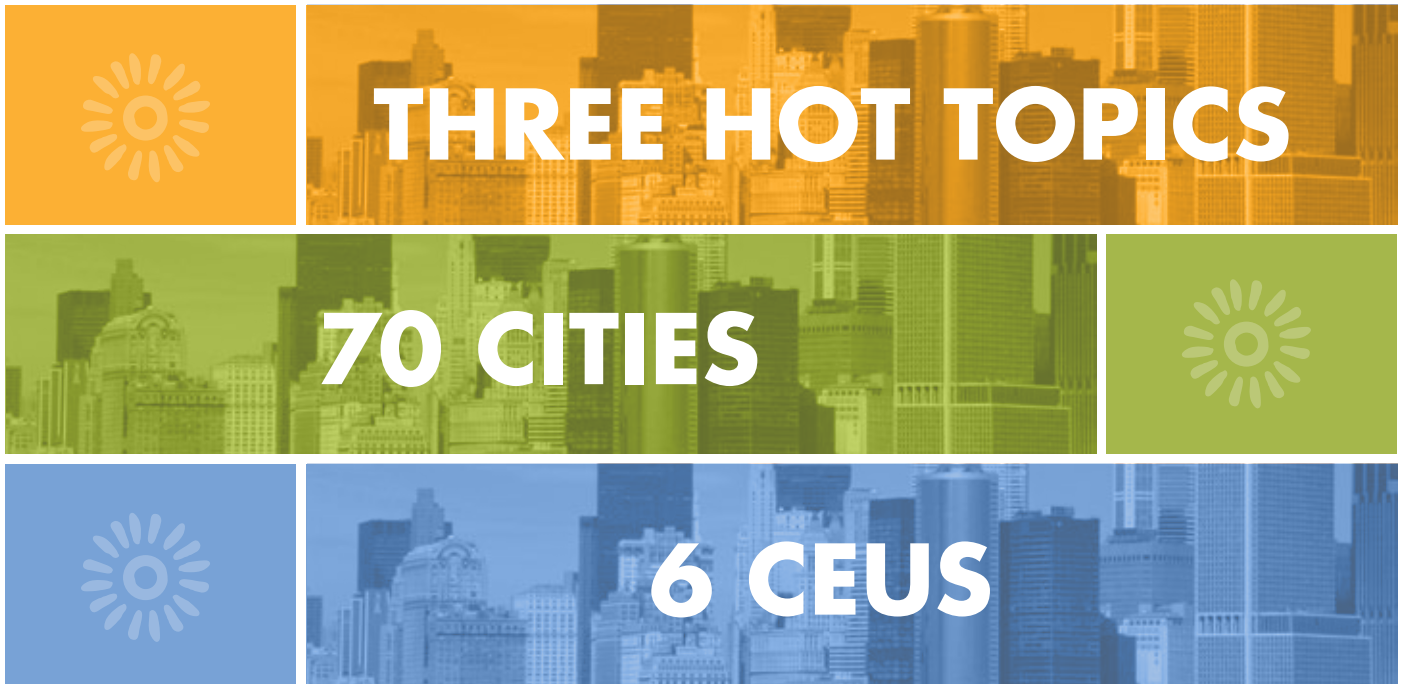

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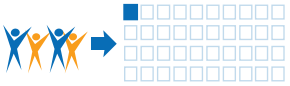

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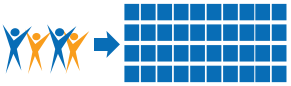

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4/16/2008	Private Payer & RAC Audits: What, Why, and How to Prepare	Joanne L Mehmert, CPC
4/23/2008	Coaching & Managing Highly Effective Coders	Lynn M Anderanin, CPC
5/7/2008	ICD-10: Implementation & Readiness – Why Coders Need to Take Notice Now!	Deborah Grider, CPC, CPC-H, CPC-P
5/14/2008	HIPAA Disaster & Recovery Plans for Physician Group Practices: You Thought You Were Covered…	Jillian Harrington, CPC
5/21/2008	Healthcare Trends to Watch: Retail Medicine, Online Positions, & the Use of New Technology	John Bishop, CPC
6/11/2008	Top Ten Claim Submission Errors & How to Avoid Them	Linda R Farrington, CPC
6/18/2008	Orthopedic Guru: The Nuts & Bolts of Coding For Orthopedic Surgeries	Lynn M Anderanin, CPC
6/25/2008	Effectively Using the Internet & Other Tools to Find Coders & Coding Jobs	Lynn M Anderanin, CPC
7/9/2008	The Basic Anatomy of an E/M Code: Selecting the Right Level of Service	Marsha Diamond, CPC, CPC-H
7/16/2008	OB-GYN Guru: Coding & Billing OB-GYN Services	Arlene Joyce Smith, CPC
7/23/2008	Climbing the Coding Ladder: How to Move Your Career to the Next Level	Lynn M Anderanin, CPC
8/6/2008	Risk Assessment: How Internal E/M Audits Can Hurt & Help Your Practice	Marsha Diamond, CPC, CPC-H
8/13/2008	Pediatric Guru: Coding & Billing Pediatric Services	Lynn M Anderanin, CPC
8/20/2008	5 Things You Need to Know About Consumer Directed Healthcare & Your Practice	Linda R Farrington, CPC
9/10/2008	Commercial Payer Audits: Post Settlement Reviews, Your Rights, Responsibilities, & What to Do About It	Joanne L Mehmert, CPC
9/17/2008	Cardiology Guru: Coding & Billing Cardiac Services & Surgeries	To Be Announced
9/24/2008	Pay For Performance In the Private Payer Market	Linda R Farrington, CPC
9/26/2008	2009 ICD-9-CM Updates	Lynn M Anderanin, CPC
10/8/2008	Stop Lost Revenue! Commonly Un-coded Services Missed With Your OV	Marsha Diamond, CPC, CPC-H
10/15/2008	Interventional Radiology Guru: Coding & Billing For Interventional RadiologyServices	To Be Announced
10/22/2008	Ancillary Services: What You Need To Know When Adding New Physician Services to Practice	Lynn M Anderanin, CPC
11/5/2008	Medical Informatics Principles – Coding, Data Mapping & the CPC	Annette Grady, CPC, CPC-H, CPC-P
11/12/2008	2009 AMA CPT-4® Update	John Bishop, CPC
11/19/2008	2009 Specialty Specific Update- Orthopaedics	Lynn M Anderanin, CPC
11/26/2008	2009 Specialty Specific Update - Anesthesia	Joanne L Mehmert, CPC
12/3/2008	2009 Specialty Specific Update - Pediatrics	Lynn M Anderanin, CPC
12/10/2008	2009 Specialty Specific Update - Cardiology	To Be Announced
12/16/2008	2009 Specialty Specific Update - Radiology	Jean Acevedo, CPC
12/18/2008	2009 Specialty Specific Update - Internal Medicine	John Bishop, CPC

* Audio conferences are subject to change

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2008 examination dates

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Atlantic		
20201-E083241	08/09/08	Washington, DC
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41009-E083363	06/28/08	Chesapeake, MD
41009-E083364	08/23/08	Chesapeake, MD
41009-E083365	11/22/08	Chesapeake, MD
30110-E083208	08/09/08	Frederick, MD
30110-E083209	12/07/08	Frederick, MD
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41015-E083381	11/01/08	Salisbury, MD
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41016-E083121	09/20/08	Towson, MD
41016-E083122	11/22/08	Towson, MD
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41208-E083329	12/06/08	Pittsburgh, PA
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Great Lakes		
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84701-E083388	12/20/08	Elgin, IL
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61803-E083412	12/06/08	Maryville, IL
61938-E080009	09/13/08	Mattoon, IL
61938-E080010	12/13/08	Mattoon, IL
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31902-E083332	08/16/08	Silvis, IL
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33016-E083450	09/20/08	Canton, OH
33016-E083451	11/15/08	Canton, OH
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61403-E080185	09/20/08	Columbus, OH
61403-E080186	12/13/08	Columbus, OH
21606-E083111	08/16/08	Independence, OH
21606-E083110	11/08/08	Independence, OH
41985-E083085	08/30/08	Lima, OH
41985-E083086	11/15/08	Lima, OH
33016-E083449	08/02/08	Smithville, OH
Mid-Atlantic		
27008-E083468	08/16/08	Barren River, KY
85901-E083437	10/11/08	Florence, KY
85901-E083438	12/13/08	Florence, KY
60605-E083056	06/27/08	Louisville, KY
60605-E083059	12/19/08	Louisville, KY
27085-E080176	10/18/08	Madisonville, KY
27085-E080177	12/06/08	Madisonville, KY
70401-E083307	06/28/08	Charlotte, NC
91918-E083255	09/20/08	Graham, NC
91918-E083256	11/15/08	Graham, NC
82816-E083336	08/23/08	Hickory, NC
82816-E083337	11/15/08	Hickory, NC
91003-E080066	09/13/08	Pinehurst, NC
91003-E080067	11/08/08	Pinehurst, NC
91910-E083048	08/02/08	Raleigh, NC
91910-E083049	10/04/08	Raleigh, NC
80302-E080107	08/16/08	Columbia, SC
80302-E080108	11/15/08	Columbia, SC
80303-E083002	08/09/08	Florence, SC
80303-E083003	11/01/08	Florence, SC
80309-E083421	08/09/08	Sumter, SC
80309-E083422	10/11/08	Sumter, SC
27641-E083136	09/20/08	Big Stone Gap, VA
27641-E083137	12/13/08	Big Stone Gap, VA
80402-E083391	09/08/08	Charlottesville, VA
80402-E083392	12/01/08	Charlottesville, VA
43413-E083224	09/20/08	Farmville, VA
43413-E083225	11/01/08	Farmville, VA
54043-E083343	08/02/08	Harrisonburg , VA
54043-E083344	11/01/08	Harrisonburg , VA
75743-E083415	08/02/08	Portsmouth, VA
75743-E083416	10/04/08	Portsmouth, VA
75743-E083417	12/06/08	Portsmouth, VA
27685-E083190	08/30/08	Richlands, VA
27685-E083191	11/22/08	Richlands, VA
54008-E083456	07/26/08	Roanoke, VA
75717-E083181	09/13/08	Virginia Beach, VA
75717-E083182	12/20/08	Virginia Beach, VA
30404-E080020	08/30/08	Charleston, WV
30404-E080021	11/15/08	Charleston, WV
30403-E083294	06/28/08	Elkins, WV
30403-E083295	09/13/08	Elkins, WV
30403-E083296	12/13/08	Elkins, WV
30410-E083425	09/20/08	Huntington, WV
30410-E083426	12/06/08	Huntington, WV
30402-E083194	09/13/08	Morgantown, WV
30402-E083195	12/13/08	Morgantown, WV
Mountain/Plains		
60201-E080077	06/28/08	Phoenix, AZ
60201-E080078	08/23/08	Phoenix, AZ
60201-E080079	12/06/08	Phoenix, AZ
52010-E083089	08/09/08	Prescott, AZ
52010-E083090	11/08/08	Prescott, AZ
60204-E080123	08/02/08	Tucson, AZ
60204-E080124	11/01/08	Tucson, AZ
71902-E083114	07/19/08	Colorado Springs, CO
71902-E083115	09/20/08	Colorado Springs, CO
CCCO6-4024	09/13/08	Loveland, CO
CCCO6-4025	11/22/08	Loveland, CO
86007-E083147	11/08/08	Windsor, CO
20801-E083354	08/16/08	Coeur d' Alene, ID
20801-E083355	11/15/08	Coeur d' Alene, ID
40602-E083263	09/13/08	Billings, MT
40602-E083264	12/13/08	Billings, MT
70102-E083444	08/09/08	Fargo, ND
70102-E083445	11/08/08	Fargo, ND
80102-E083250	07/19/08	Salt Lake City, UT
80102-E083251	10/18/08	Salt Lake City, UT
80102-E083252	12/13/08	Salt Lake City, UT
Northeast		
86007-E083145	07/19/08	Windsor, CT
86007-E083146	09/20/08	Windsor, CT
20704-E080109	07/26/08	Bangor, ME
20704-E080110	10/25/08	Bangor, ME
60302-E083441	09/06/08	Salem, NH
60302-E083442	11/01/08	Salem, NH
51625-E083023	11/01/08	Garden City, NY
51625-E083021	06/28/08	Long Island, NY

Index	Date	City/State
51625-E083022	08/23/08	Long Island, NY
Southeast		
20501-E083177	09/13/08	Birmingham, AL
20501-E083178	11/15/08	Birmingham, AL
25609-E083060	11/08/08	Hunstville, AL
25609-E083018	06/28/08	Huntsville, AL
25609-E083019	09/13/08	Huntsville, AL
27085-E080175	08/23/08	Madisonville, AL
20507-E083093	07/12/08	Montgomery, AL
20507-E083094	10/11/08	Montgomery, AL
33414-E083139	07/12/08	Opp, AL
33414-E083140	08/16/08	Opp, AL
33414-E083141	12/13/08	Opp, AL
94123-E083006	09/13/08	Cape Coral, FL
94123-E083007	12/06/08	Cape Coral, FL
81334-E083168	09/20/08	Clearwater, FL
81334-E083169	12/13/08	Clearwater, FL
40738-E080190	08/09/08	Daytona Beach, FL
40738-E080082	11/08/08	Daytona Beach , FL
95485-E080061	08/10/08	Ft. Laduerdale , FL
95485-E080062	11/08/08	Ft. Lauderdale, FL
35215-E083370	08/09/08	Gainesville, FL
35215-E083371	11/08/08	Gainesville, FL
CCFL30-4037	11/13/08	Hollywood, FL
90420-E083267	09/13/08	Jacksonville, FL
94119-E083259	09/27/08	Lakeland, FL
90420-E083268	12/13/08	Lakeland, FL
94119-E083260	12/13/08	Lakeland, FL
CCFL29-3980	06/28/08	Miami, FL
CCFL29-3981	07/26/08	Miami, FL
CCFL29-3982	08/30/08	Miami, FL
CCFL29-3983	09/27/08	Miami, FL
CCFL29-3984	10/25/08	Miami, FL
CCFL29-3985	11/29/08	Miami, FL
CCFL29-3986	12/19/08	Miami, FL
72740-E083350	06/28/08	New Port Richey, FL
72740-E083351	09/27/08	New Port Richey, FL
72740-E083360	12/27/08	New Port Richey, FL
56126-E083164	09/13/08	Palm Springs, FL
56126-E083165	12/13/08	Palm Springs, FL
56122-E083237	08/23/08	Port St Lucie, FL
56122-E083238	11/15/08	Port St Lucie, FL
CCGA31-3995	07/12/08	Atlanta, GA
CCGA31-3996	08/09/08	Atlanta, GA
40404-E083246	08/16/08	Atlanta, GA
CCGA31-3997	09/20/08	Atlanta, GA
40404-E083247	10/18/08	Atlanta, GA
CCGA31-3998	10/18/08	Atlanta, GA
CCGA31-3999	11/15/08	Atlanta, GA
CCGA31-4000	12/13/08	Atlanta, GA
22917-E083077	07/24/08	Donalsonville, GA
22917-E083078	10/23/08	Donalsonville, GA
77005-E083127	08/12/08	Gainesville, GA
77005-E083128	10/14/08	Gainesville, GA
77005-E083129	12/02/08	Gainesville, GA
77009-E083203	09/13/08	Marietta, GA
91213-E083374	06/28/08	Savannah, GA
91213-E083375	09/20/08	Savannah, GA
91213-E083376	11/15/08	Savannah, GA
93111-E083279	08/23/08	Cookeville, TN
93111-E083280	11/08/08	Cookeville, TN
73110-E083052	08/23/08	Jackson, TN
73110-E083053	11/15/08	Jackson, TN
61507-E080157	09/13/08	Kingsport, TN
61507-E080158	12/13/08	Kingsport, TN
61502-E080099	07/19/08	Knoxville, TN
61502-E080100	10/18/08	Knoxville, TN
61506-E083073	08/16/08	Nashville, TN
61506-E083074	11/15/08	Nashville, TN
Southwest		
87005-E083317	11/01/08	Cherokee Village, AR
47906-E083271	09/20/08	Fort Smith, AR
47906-E083272	11/08/08	Fort Smith, AR
87005-E083316	08/23/08	Jonesboro, AR
50101-E083291	08/02/08	Little Rock, AR
50102-E083287	09/27/08	Little Rock, AR
50101-E083292	10/04/08	Little Rock, AR
50102-E083288	11/08/08	Little Rock, AR
78508-E083041	09/06/08	Lawrence, KS
78508-E083042	11/01/08	Lawrence, KS
22508-E080202	08/16/08	Baton Rouge, LA
22508-E080203	10/11/08	Baton Rouge, LA
31807-E080074	08/02/08	Bossier City, LA
98501-E083063	09/13/08	Covington, LA
50402-E083324	07/19/08	Jefferson, LA
50402-E083325	11/15/08	Jefferson, LA
31402-E080143	08/16/08	Chesterfield , MO
31402-E080144	11/08/08	Chesterfield , MO
31401-E083216	08/09/08	Columbia, MO
31401-E083217	11/08/08	Columiba, MO
57301-E080191	06/28/08	Jefferson City, MO
81603-E080030	07/26/08	Kansas City, MO
81603-E080029	11/22/08	Kansas City, MO
81603-E080028	09/20/08	North Kansas City, MO
31402-E080140	09/27/08	St Louis , MO
40503-E083275	10/18/08	Moore, OK
40503-E083276	12/06/08	Moore, OK
74055-E083319	06/28/08	Tulsa, OK
91802-E083011	09/06/08	Tulsa, OK
74055-E083320	09/13/08	Tulsa, OK
74055-E083321	12/06/08	Tulsa, OK
91802-E083010	12/06/08	Tulsa, OK
51216-E083402	08/23/08	Austin, TX
51216-E083403	11/15/08	Austin, TX
90328-E083081	09/20/08	Denison, TX
90328-E083082	11/15/08	Denison, TX
91527-E080024	08/02/08	El Paso, TX
91527-E080025	11/01/08	El Paso, TX
40901-E083067	08/16/08	Houston, TX
40901-E083068	10/11/08	Houston, TX
40901-E083069	12/20/08	Houston, TX
80624-E083282	07/12/08	Lubbock, TX
80624-E083283	09/06/08	Lubbock, TX
80624-E083284	12/20/08	Lubbock, TX
21430-E080189	11/01/08	Richardson, TX
21020-E080037	07/19/08	San Antonio, TX
21020-E080038	08/23/08	San Antonio, TX
21020-E080039	09/20/08	San Antonio, TX
21020-E080040	10/25/08	San Antonio, TX
21020-E080041	11/15/08	San Antonio, TX
West		
90701-E080115	08/09/08	Anchorage, AK
90701-E080116	11/08/08	Anchorage , AK
90702-E080154	09/13/08	Fairbanks, AK
90702-E080155	12/06/08	Fairbanks, AK
71437-E083397	07/19/08	Anaheim, CA
71437-E083398	11/15/08	Anaheim, CA
71412-E083099	09/13/08	Long Beach, CA
71412-E083100	12/13/08	Long Beach, CA
92524-E083406	07/26/08	Martinez, CA
92524-E083407	10/27/08	Martinez, CA
92524-E083408	11/22/08	Martinez, CA
91622-E083358	09/20/08	Sacramento, CA
91622-E083359	12/13/08	Sacramento, CA
61906-E083460	08/30/08	San Diego, CA
70742-E083014	09/20/08	Santa Rosa, CA
70742-E083015	11/15/08	Santa Rosa, CA
80803-E083383	08/09/08	Wailuku, HI
80803-E083384	11/08/08	Wailuku, HI
70201-E080165	08/16/08	Las Vegas, NV
70201-E080166	11/15/08	Las Vegas, NV
50301-E080053	07/19/08	Portland , OR
50301-E080054	08/16/08	Portland, OR
50301-E080055	09/20/08	Portland , OR
50301-E080056	10/12/08	Portland , OR
50301-E080057	11/15/08	Portland , OR
50301-E080058	12/13/08	Portland , OR
20622-E080147	06/28/08	Everett, WA
20622-E080148	09/20/08	Everett, WA
20622-E080149	11/08/08	Everett, WA
25317-E080119	09/27/08	Lakewood, WA
36014-E083212	09/20/08	Olympia, WA
36014-E083213	12/06/08	Olympia, WA
25317-E080120	12/13/08	Puyallup, WA
20608-E083432	06/28/08	Seattle, WA
20608-E083433	08/23/08	Seattle, WA
20608-E083429	09/27/08	Seattle, WA
20608-E083430	10/25/08	Seattle, WA
20608-E083434	11/22/08	Seattle, WA
36020-E083340	09/06/08	Vancouver, WA
36020-E083341	11/01/08	Vancouver, WA
50912-E080170	09/27/08	Wenatchee, WA
50912-E080163	11/15/08	Wenatchee, WA

TOP 10
Common ICD-9-CM Coding Errors

- **Coding straight from the index**. You have to read the notes in the tabular section to be sure your selection is correct.
- **Sequencing codes inappropriately**. Code the underlying disease BEFORE the manifestation; the injury BEFORE the E code.
- **Assigning too few codes**. If an underlying condition is a factor in today's treatment, sequence it secondarily.
- **Assigning too many codes**. If a chronic condition isn't part of today's treatment or care plan, it needn't be reported.
- **Trusting your code book's guidelines**. Of course you need to follow the guidelines, but keep in mind, the official ICD-9-CM guidelines are released in October, long after the books are printed. Make sure you download the latest updates each fall at www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines.
- **Coding rule-out diagnoses**. If a test result is negative, DO NOT code the suspected diagnosis to justify the test. Symptom codes get the doctor paid without compromising the codified medical history of the patient.
- **Conserving space by using fewer digits**. Make sure that if a condition provides for details in fourth or fifth digits, you are using them. A truncated code is an invalid code and the quickest road to a claim denial.
- **Settling for something vaguely appropriate**. Don't settle for "other and unspecified" or "other specified," unless you have exhausted all other possibilities.
- **Letting time get away from you**. Use the current year's code book to ensure you are using the current year's codes—or, if you are filing a claim for last year, use last year's codes.
- **Thinking ICD-9-CM codes aren't "money codes."** If the codes are old: DENIAL. If the codes are truncated: DENIAL. If the wrong codes are assigned or the sequencing is wrong: DENIAL. Denials cost money.

American Academy of Professional Coders
www.aapc.com

The Coder's TOOLBOX

www.cms.hhs.gov

by Linda Templeton, CPC, CPC-H, CCS-P

We all know how frustrating it is to try and complete a project when you don't have the right tools. The most skilled in a trade find themselves collecting so many tools that it's hard to remember where the most basic and useful items are. As coders, we are bombarded with so many resources that we are overwhelmed and frustrated with information overload.

The Centers for Medicare and Medicaid Services' (CMS) and Medicare carriers' Web sites are a coder's perfect set of tools. With a little searching and determination, you'll be surprised to find that most everything you need to know about coding and submitting claims correctly is right there at your fingertips.

I find that keeping my resource "toolbox" down to the basic essentials minimizes my frustration. With the vast amount of coding and billing resources available, we can't be certain of getting the most accurate information. My advice to new coders is to go back to CMS resources and confirm any information obtained from other sources.

My favorite CMS web tools to use are the following:

Physician Fee Schedule Look-up

This is an excellent resource. With this tool, we can research a specific HCPCS Level II or CPT® code and find pricing amounts, various payment policy indicators, relative value units (RVUs), and geographic practice cost indexes (GPCIs) by a single procedure code, a range of codes, and a list of procedure codes. With this tool you can also find information regarding global days for surgical procedures and physician supervision requirements. All of this information is at one location and alleviates the task of searching several areas to obtain the information you are seeking.

To access this tool, follow these steps:

- Go to **www.cms.hhs.gov/PFSlookup/.**
- Select "Physician Fee Schedule Search" on the menu to the left of the page.
- Read the instruction sheet titled "Help with Physician Fee Schedule Search" to guide you until you are familiar with the tool.

NCCI Policy Manual for Part B Medicare Carriers, and NCCI Edits

Most of us are familiar with the National Correct Coding Initiative (NCCI) edit tables. However, not as many of us are familiar with the NCCI Policy Manual as a source of coding information for a particular specialty. It's a great resource for NCCI or "bundling" edits, and the chapter guidelines provide detailed information of the rationale behind the edits. I print this out each year and create a binder organized by CPT® section that I can use for reference. You may prefer to save it to your desktop or add it to your "Favorites" or "Bookmarks" for handy reference.

I recommend reading Chapter 1 of the NCCI Policy Manual prior to interpreting the NCCI edit tables. This chapter provides an easy-to-understand explanation of how to interpret the tables and the rationale behind the edits. To find the Policy Manual, follow these steps:

- Go to **www.cms.hhs.gov.**
- Select the Medicare tab on the top-left portion of the web page.
- Scroll down to the "Coding" section.
- Click the National Correct Coding Initiative Edits link.
- Scroll down to the "Downloads" section and select NCCI Policy Manual for Part B Medicare Carriers.
- Open the zip file and select CHAP1final083107.

Under the "Related Links Inside CMS" section, you can browse through NCCI FAQs to find some interesting questions and answers about related topics.

The remaining chapters provide coding guidelines relating to specialties, and correspond with the chapters of the CPT®. For hospital outpatient prospective payment system (OPPS) setting, see the hospital center and NCCI Edits for OPPS.

Medicare Coverage Center

Having a good understanding of the coverage guidelines specific to your specialty services is essential to your practice or facility. You can access the local coverage decisions (LCD) and national coverage decisions (NCD) that relate to your specific area of coding at: **www.cms.hhs.gov/center/coverage.asp.**

The Medicare Coverage Database provides several ways to locate and view data. Here are a few you may find useful:

- **Indexes.** Provide users with pre-defined lists of National and local coverage documents.
- **Searches.** Allows users to search both the NCD and LCD databases using a variety of criteria such as key word, coverage topic, and date.
- **Reports.** Provides users with reports of National and local coverage data.
- **Downloads.** Allows users to download complete sets of LCDs and articles and the complete set of NCDs.

When it's time to clean out your coding toolbox, the CMS Web site is definitely the tool to keep!

Open Door Forums

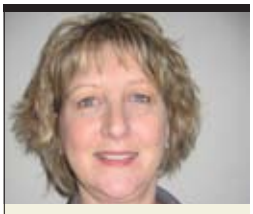
The CMS Open Door Forum is a free teleconference allowing the provider community to participate in live discussions with CMS. They provide a place for providers and CMS to help identify and clarify issues for resolution. Here, relevant issues to providers can be discussed with CMS officials and other colleagues in your area. The Open Door Forums are held every four to six weeks with 16 ongoing forums in specialized topic areas.

The participants learn from this dialogue to clarify surrounding coverage, coding and payment. Comments can be submitted to the panel before the sessions. To participate in the event, register and sign up to receive email notifications prior to each forum discussion.

For more information and to sign up for email notifications, go to: **www.cms.hhs.gov/OpenDoorForums/**.

Archived forums area available if you miss the live presentation, or if you want to review the presented information at a later date.

Besides using the above CMS Web site resources, you should become familiar with your local carrier Web site for the most current coding information. When it's time to clean out your coding toolbox, the CMS Web site is definitely the tool to keep!



Linda Templeton, CPC, CPC-H, CCS-P, has 25 years experience in HIM, coding, practice management and consulting. She is a hospital Outpatient Coding Specialist in SE Michigan, and is also a Coding Instructor at Stautzenberger College in Maumee, Ohio. She is the former President of the Toledo, Ohio chapter of AAPC.

An Usual Case of Respiratory Distress in an Infant

In February, we discussed a case of an infant presenting with significant respiratory distress. Physical examination revealed a palpable mass on the right flank. An ultrasound of the abdomen showed a right-sided cystic mass containing multiple calcifications and the MRI revealed a round head-like structure and long bone-like calcifications. Physicians suspected she might have fetus-in-fetu and set out to remove the mass. During a laparotomy, the mass was removed and sent to pathology.

Dr. Mohd Ali Hadi, CPC-H, Aligarh, Uttar Pradesh, India contacted us and let us know the codes should be CPT® code 49205 and ICD-9-CM Vol 2 codes 782.2, 518.82 and Vol. 3 code 54.4.

49205 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor greater than 10.0 cm diameter*

782.2 *Localized superficial swelling, mass, or lump*

518.82 *Other pulmonary insufficiency, not elsewhere classified*

54.4 *Excision or destruction of peritoneal tissue*

In this case, the fetus-in-fetu is only confirmed after the pathology report, but at the time of the excision it was just a mere retroperitoneal mass. Also, note code 49205 is taken by default since the mass weighs 1200 grams.

Can You Code This Note?

A Complicated Nephrectomy

Cardiovascular procedures can be particularly difficult thanks to the complexity of the arteries, veins, and their orders, Surgeons often are forced to route grafts where possible, and the failure of an artery can lead to dramatic consequences. Below is one of those cases, where the occlusion of an artery requires significant work. How would *you* code the case below?

Indications: The patient, who has a history of poorly controlled hypertension, presented with symptoms of acute renal failure. Tests showed elevated levels of rennins and radiographs indicated superior mesenteric artery occlusion and high-grade stenosis of the celiac axis, which had caused the left kidney to atrophy.

Procedure: The patient was prepped and placed under anesthesia. The physician made an incision into the abdomen, took down the left triangular ligament under direct vision of the liver, and placed two renal retractors on the liver's edge to allow exposure of the lesser sac. The lateral abdominal wall was elevated with Cheyne retractors with Omni facilitated exposure. The esophagus was mobilized, tied off, and placed in traction and the stomach was elevated upward and to the left. The crura were taken down, exposing the aorta and the supraceliac. The physician began dissection distally in an effort to identify the splenic artery. The splenic artery coursing medially to laterally was just above this area and the physician elected to simply expose the splenic vessel rather than continue dissection. Vessel loops were passed and he moved to the superior mesenteric artery (SMA). The inferior border of the pancreas was clearly defined and the superior mesenteric vein fully exposed. The physician traced the middle colic artery to the small attenuated SMA, which was placed posterior to the pancreas where it became attenuated. It was also a thin-walled vessel but with excellent Doppler signal. The physician began the nephrectomy and mobilized the Gerota's fascia and the kidney. He divided the renal vein between silk ties and a hemoclip. An inferior pole vessel was ligated with hemoclips and the entire specimen mobilized with the ureter attached. It was clipped proximally with a large clip, distally with two large clips and subsequently divided, and the kidney removed. The patient received 6000 units of IV heparin. Utilizing a side-biting angled aortic clamp, partial occlusion of the supraceliac aorta was achieved and a 12 x 6 bifurcating graft was cut obliquely just above the bifurcation of the graft. This facilitated an angled anastomosis to the supraceliac aorta. A pledget and horizontal suture at the inferior heel was placed and hemostasis further assured with a traction suture of 4-0 Prolene. This was checked and clamps placed along the limbs. Good urine output had occurred with this prompt anastomosis with very little ischemic time to the only kidney. The physician passed the SMA limb to the SMA cutdown site posterior to the stomach above the pancreas, where it lay nicely, to the fully exposed SMA. He cut the superior limb to facilitate anastomosis to the celiac access, securing it in an oblique fashion to the large splenic artery with 6-0 Prolene. A similar anastomosis was fashioned into the SMA with running 6-0 Prolene suture and flow restored to the SMA upon completion. Excellent Doppler signals along the mesenteric border of the bowel and excellent pulse in the vessels perfused by the new graft limb at the SMA level were identified. The physician then found bleeding in the left upper quadrant and a small capsular avulsion of the spleen. After failing to stop the bleeding using manual compression and topical thrombin-soaked Gelfoam, the physician removed the spleen via mobilization of the lienorenal ligament, elevation of the spleen, takedown of short gastrics between multiple hemoclips, and ligation of the splenic artery and splenic vein branches with multiple hemoclips. He placed a flat drain exiting in the left lower quadrant and secured it with 2-0 silk. The abdomen was closed with interrupted sutures, subcutaneous with sutures, and skin with staples.

Submitted by
Karla D. Garcia, CPC Kevil, Ky.

Have You Gone to Extremes?

Have you got a challenging scenario you'd like to see discussed in this forum? Send your op report to extreme.coding@aapc.com. Before forwarding it to us, please safeguard the patient's personal information by changing dates and removing unique identifiers.

Chargemaster Maintenance:

Correct, Complete and Compliant Coding

by Vicki Fry, MS, MBA

To simplify chargemaster maintenance let's focus on three key issues in each hospital department: correct, complete, and compliant coding (aka the three Cs). Periodic chargemaster reviews systematically verify that the correct HCPCS Level II and CPT® codes are assigned to each line-item, they make sure the departments have a complete array of codes to report all services provided and that all chargemaster line-items are compliantly reported to assure accuracy and reduce the effort necessary for maintenance.

First C: Correct Codes

Understanding what service, procedure, or supply/pharmaceutical is provided when a line-item is charged to a patient is the first step to ensure the correct codes are assigned for each chargemaster line-item. Since many departments use chargetickets or electronic charge entry to record services mapped to a chargemaster procedure number, interviewing staff and reviewing chargetickets/charge entry software mapping is a necessary first step. It's very common to find inaccuracies between what a department is capturing on their chargeticket and what is being reported on a chargemaster. For example, when therapeutic infusions on a chargeticket are mapped to hydration codes on the chargemaster, or bilateral imaging procedures are mapped to unilateral procedures. Each inconsistency between the chargeticket and the chargemaster must be corrected by either changing the department's document and/or software or the chargemaster.

After verifying the appropriateness of each chargemaster line-item description for the service, determine if the correct HCPCS Level II, CPT® and revenue code is present. To do so:

- Change codes that do not accurately represent the service provided
- Add codes for all line-items that should be reported with a CPT®/HCPCS code
- Determine if hard-coded modifiers are needed
- Scrutinize "unlisted" code line-items
- Remove codes from line-items that are coded by HIM

Common correct code errors to look for are:

- Missing or inaccurate modifiers for radiology, physical/occupational/speech therapy, and other procedures
- Assigning an unlisted HCPCS code when a specific code is available
- Missing HCPCS codes for pharmaceuticals that are separately paid
- Missing HCPCS C codes for devices that have associated CMS device/procedure edits
- Assigning an inappropriate supply/device C code
- Assigning a CPT® code when an alternate HCPCS code is necessary for Medicare billing
- Assigning a deleted or non-billable HCPCS code

Second C: Complete Codes

To review for complete codes make sure each department has sufficient chargemaster line-items to capture all of the services, procedures, or supply/pharmaceuticals provided to their patients. Frequently, departments do not charge for all services rendered because they are not aware of the proper use or availability of HCPCS codes. You can determine if departments have the complete ranges of chargemaster codes and line-items by:

- Understanding what services are provided
- Asking department staff if they provide services they either don't charge for or don't have an appropriate line-item to use to report the service

- Reviewing new codes with staff to determine if they should be added to the chargemaster
- Checking what applicable codes are not on the chargemaster and asking if they should be included

Using this process improves complete coding by identifying when, for example, missing E/M levels of care, infusion codes, contrast and radiopharmaceuticals, add-on codes, etc. should be added to departments' chargemasters.

For a complete code review, you should verify that chargemaster and chargeticket line-items accurately describe the unit being captured. Each unit-specific code line-items such as add-on codes, anatomy codes, time or age-specific codes, pharmaceutical dose codes, should identify the accurate billing unit in the description. Include descriptors such as "EA ADD," "BIL," "PER ML," etc. to increase accuracy and charge capture.

Common complete code errors to look for are:

- Missing E/M Level of Care codes
- Missing observation codes
- Missing drug administration (injection/infusion) codes
- Missing or inappropriate use of add-on codes
- Missing radiology contrast and radiopharmaceutical codes
- Missing codes for procedures reported with more than one HCPCS code (i.e., S&I code with missing associated injection code)
- Missing or inaccurate unit in pharmaceutical description

Third C: Compliant Codes

The final issue in reviewing and maintaining chargemasters is to assure all codes are compliant with coding conventions and federal, state and other third-party payer rules and regulations. Reviewing for compliant codes includes confirming that chargemaster line-items are both used and reported consistent with rules. The best way to accomplish compliant code is to interview department staff for verification. Ask the staff specific questions concerning compliant service code use to determine their general compliance knowledge and adherence. Regular compliance communication and education is also advisable. At a minimum, compliance education should include the following:

- Coding conventions, bundling/unbundling rules, CCI edits, OCE edits

Frequently, departments do not charge for all services rendered because they are not aware of the proper use or availability of HCPCS codes.

- Medicare, Medicaid, and other state regulations and coverage rules
- FI-specific requirements
- Documentation requirements
- Licensure billing requirements
- Corporate compliance guidance/rules (if applicable)

Next, the chargemaster should be reviewed to identify, modify or remove line-items that should not be reported separately or are being inaccurately reported. This review should include the following:

- Identifying all routine supplies that are not separately billable
- Assuring all line-items that include supplies with descriptors that include kit, tray, set, etc. are only billing for separately billable contents and all contents are documented
- Making sure self-administrable drugs have appropriate revenue codes
- Checking commonly unbundled codes and/or separate procedure codes for appropriateness
- Verifying method-specific laboratory codes are described appropriately laboratory panels are not unbundled, "miscellaneous" line-items are used judiciously, etc.)
- Discussing noncompliant line-items and modifications or removal with department managers prior to action

Common compliant code errors to look for are:

- Inaccurate Pharmacy HCPCS code assignment
- Inaccurate revenue code assignment on non-injectable drugs
- Inaccurate HCPCS and revenue code assignment on FI-designated Self Administrable Drugs (SAD)
- Inappropriate reporting of routine supplies
- Inappropriate reporting of equipment
- Excessive use of "miscellaneous" line-items when service specific line-items should be developed

Ongoing Chargemaster Maintenance

Focusing on correct, complete, and compliant coding in reviewing department chargemasters streamlines the ongoing chargemaster maintenance. Ultimately, maintenance results in all chargemaster issues being addressed and requiring less effort.

Vicki Fry, MS, MBA, is a senior consultant with Prospective Payment Specialists, providing chargemaster reviews and ongoing maintenance for hospitals ranging from small CAHs to university medical centers and national corporations. Vicki has 20 years of coding experience, has been an AAPC National Conference speaker, and has published over 50 coding articles. She can be contacted at vicki.fry@ppscompliance.com.

Judith Houston, CPC

Coding teacher at Cecil College and founder of the Chesapeake Chapter of Elkton, Md.

Coding Edge (CE): 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.?

Judith: I have been in the medical profession since 1964. I first worked part time in our local physician's office at night and on weekends during high school. After high school, I worked in a hospital laboratory in Dearborn and Pontiac, Mich. After marriage, I moved to the Delaware and Maryland area and raised my three children while volunteering at the Veteran's Administration in our area. I started teaching medical assistants at Cecil College in coding, billing, medical laboratory procedures and phlebotomy in in 1990. Now, I primarily teach the coding classes there. I also researched for Ingenix' *Coders' Dictionary,* consulted for several physicians' offices, nursing homes, medical marketing companies, spoke at local seminars and wrote the *3 in 1 Coding Concepts* textbook, which is on the vendors list for 24 CEUs from the AAPC.

CE: What is your involvement level with your local AAPC chapter?

Judith: I founded the Chesapeake Chapter of Elkton, Md. in 2002. I served in all the officer positions except for Secretary. I help by working on and planning our seminars and workshops.

CE: What has been your biggest challenge as a coder?

Judith: One of the biggest challenges as a coder is getting physicians to properly document. Another challenge is developing a quality program at our college for medical coding that meets the standards of the AAPC. We have a wonderful first time passage rate for our students taking the CPC® exam!

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart?

Judith: In the past, I approached him as soon as possible. We also held weekly meetings with all the staff to update everyone involved with changes or problem areas in our coding/billing.

CE: If you could have any other job, what would it be?

Judith: I'd be a wedding or tour coordinator. I did it for a short time and loved it!

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

Judith: I have been married for 38 years. I have three grown children, a son and two daughters, two granddaughters and a very spoiled springer spaniel named Princess. I love to read, teach and go to the Outer Banks of North Carolina with friends and family.

Want to Contribute to Coding Edge?

Questions? Contact Michelle.Dick@aapc.com or Brad.Ericson@aapc.com or call 1-800-686-CODE.

Submission Guidelines

Coding Edge welcomes your article queries and submissions. Proposed articles and submissions should address the actual practice of coding and billing.

Coding Edge reserves the right to edit and/or reject any submission. We ask that when you submit an article that it meet the following criteria:

Format—Articles should be submitted electronically as a spell-checked, formatted Word document. We cannot publish PowerPoint presentations, but we can help you turn them into articles.

Length—Articles should be between 1000 to 2000 words.

Grammar and Style—We use The Associated Press Stylebook, The Chicago Manual of Style, and the American Medical Association (AMA) Manual of Style as the final words on style and grammar.

Citations or sources—Please list them separately after the article or attribute them in the text if you wish to cite sources. You may include website URLs in your article. Formal academic-style footnotes are discouraged.

Codes—CPT®, ICD-9-CM, or HCPCS Level II codes must be accompanied with full code descriptions. Please avoid confusing your readers by paraphrasing descriptions or using unofficial short descriptions.

By-lines—Submissions should be written or co-written by certified coders or licensed clinicians.

About you—Include a 50-word biography and an original high-resolution photo (no web photos) for each author.

Coding Edge Tests Your Knowledge

April 2008

These questions are answered in articles throughout this news magazine. For answering all questions correctly, you will receive one CEU at the time of your renewal. These CEUs are awarded in addition to the CEUs available annually for submitting summaries from *Coding Edge*. Please do not submit until your renewal date. Use this number on the AAPC website CEU tracker for this issue. Use CE03002008A for the March issue.

Index: CE04002008A

1. **When coding wound repair in CPT®, you should report laceration length how?**
   a. By inches, rounding to the nearest quarter down
   b. By centimeters, rounding to the nearest tenth down
   c. By inches, rounding to the nearest quarter up
   d. By centimeters, rounding to the nearest tenth up
2. **A major ICD-9-CM coding error is:**
   a. Assigning too few codes
   b. Thinking ICD-9-CM codes aren't "money codes"
   c. Coding rule-out diagnoses
   d. All of the above
3. **A common chargemaster coding error is:**
   a. Assigning a code recommended by the Outpatient Code Editor
   b. Using the code you know will be accepted
   c. Making the chargeticket and chargemaster match
   d. Missing codes for pharmaceuticals that are separately paid
4. **When investigators show up with a search warrant you should:**
   a. Encourage your employees to let them expand their search
   b. Refuse to cooperate and hide the files requested
   c. Set up one-on-one private meetings between investigators and employees
   d. Review the search warrant to determine its scope and limits
5. **The NCCI policy manual defines global package as:**
   a. Inclusive of all care and visits until the patient is cured
   b. Inclusive of most services save for post-procedure
   c. Inclusive of the procedure and aftercare only
   d. Inclusive of pre-, intra- and post-procedure
6. **A new ICD-9-CM code has been included for the following:**
   a. Jaundiced iris syndrome
   b. Twitchy lid syndrome
   c. Evil eye syndrome
   d. Floppy iris syndrome
7. **HCPCS Level II codes are developed by:**
   a. Panels of physicians and drug reps with input from payers
   b. HHS legal and administrative staff with input from the President
   c. Coding book publishers with input from purchasers
   d. HHS HCPCS Work Group with input from a number of constituents
8. **A big mistake in ICD-9-CM coding is when a coder:**
   a. Codes from the tabular section rather than the index
   b. Consults the neoplasm table for oncology diagnoses
   c. Conserves space by using fewer digits
   d. Codes to the greatest level of specificity
9. **Include clubbing where it**
   a. Best raise the complexity of decision making to high
   b. Best supports the procedure performed
   c. Best supports the presenting problem
   d. Best defends the documentation
10. **The cause or mechanism of clubbing is**
    a. Gout
    b. We don't know
    c. Cardiovascular
    d. Pulmonary

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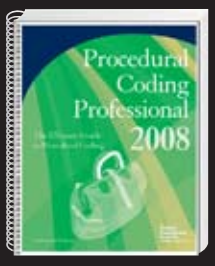

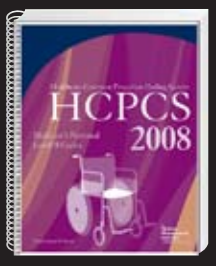

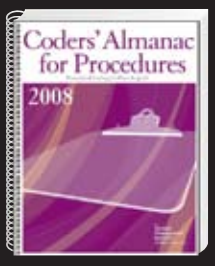

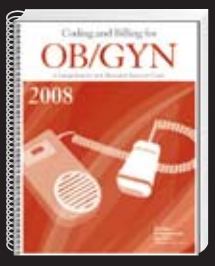

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