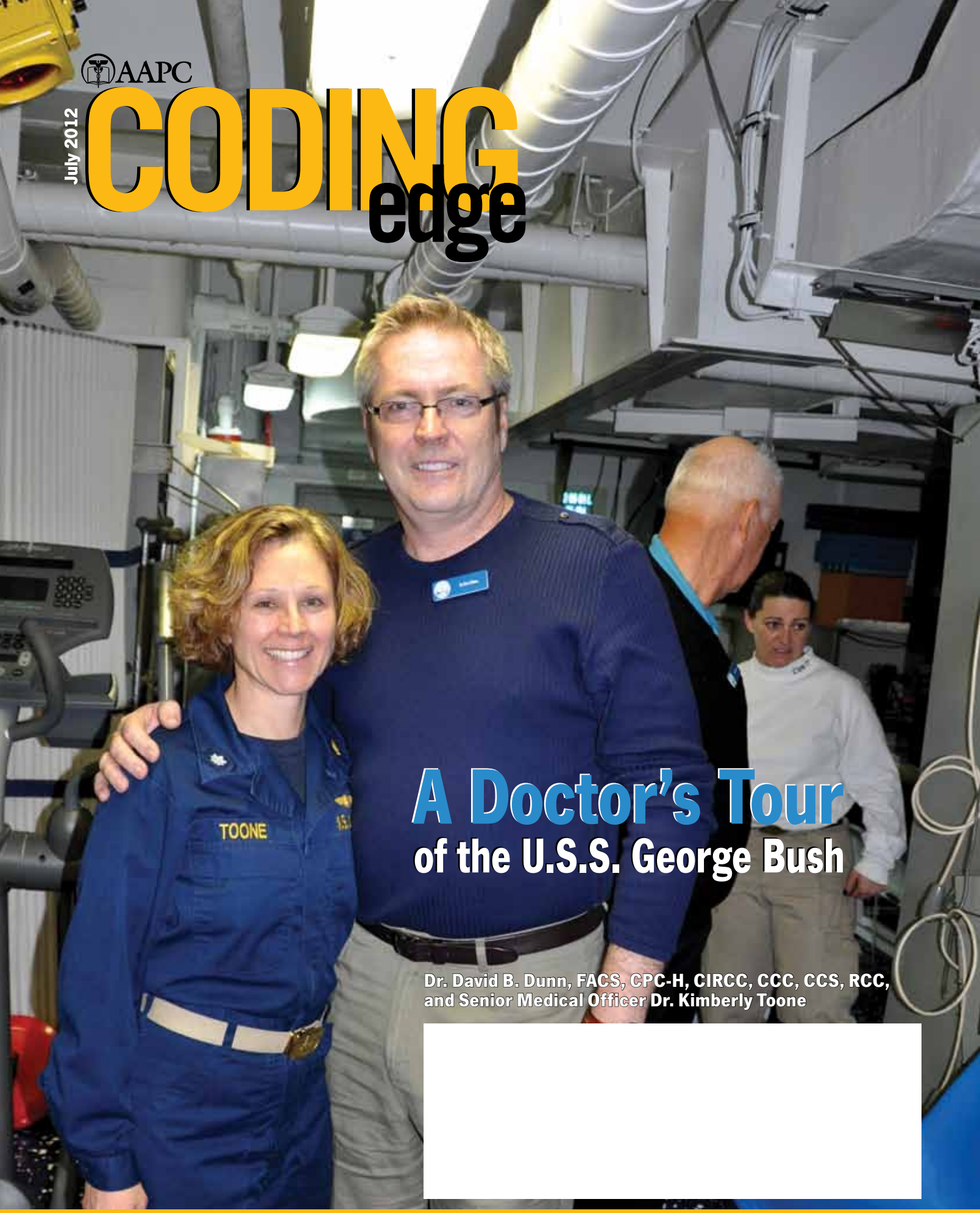
AAPC
July 2012

CODING edge



A Doctor's Tour of the U.S.S. George Bush

Dr. David B. Dunn, FACS, CPC-H, CIRCC, CCC, CCS, RCC, and Senior Medical Officer Dr. Kimberly Toone

Plus: TEE and OLV • +15777 • EMG with NCV • Exam Tips • DME • Group Therapy

Register at ama-assn.org/go/symposia today!

See you in November!

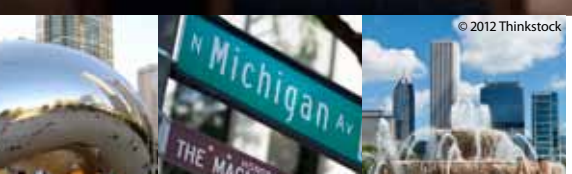
The premier *coding and reimbursement* event

2013 CPT® and RBRVS Annual Symposium

Nov. 14-16, 2012
Marriott Chicago Magnificent Mile

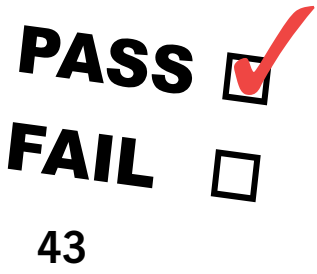
Learn what you need to know for 2013 from the source of CPT®—the AMA!

Back by popular demand!
ICD-10-CM Chicago Workshop
Nov. 13-14, 2012, directly preceding the Symposium



Visit ama-assn.org/go/symposia **or call (800) 621-8335 to learn more and register!**

AMA
AMERICAN MEDICAL ASSOCIATION



[contents]

AAPC CODING edge
July 2012

Features

On the Cover: *Senior Medical Officer* **Dr. Kimberly Toone** *leads a distinguished visitor's tour of the medical facilities on the Navy's U.S.S. George H.W. Bush with National Advisory Board (NAB) President-elect* **Dr. David B. Dunn**.

In Every Issue

Special Features

Education

Coming Up

- **E/M Modifiers**
- **Contract Negotiations**
- **Bedside Ultrasounds**
- **Risk Adjustment**
- **PQRS G Codes**

Serving 115,000 Members – Including You!

Be Green!

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

Here are some great reasons:

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

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

advertising index

AAPC CODING edge
July 2012

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

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

Volume 23 Number 7 July 1, 2012

Coding Edge (ISSN: 1941-5036) is published monthly by AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208, for its paid members. Periodicals Postage Paid at Salt Lake City UT and at additional mailing office. POSTMASTER: Send address changes to: Coding Edge c/o AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208.

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

We make it easy to stay up-to-date.

http://go.cms.gov/about-mln

You want to further your understanding of the Medicare Program. As the official source of CMS information for Medicare Fee-For-Service providers, the **Medicare Learning Network® (MLN)** offers a comprehensive selection of booklets, guides, podcasts and web-based training courses to keep you in-the-know. You can download many of these free resources to help you understand coverage and billing requirements.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

AAPC

Suffering from *Pathophysi-itis?*

Pathophysi-itis: (path-o-fizz-e-itis) A syndrome affecting coders whose accuracy and efficiency is greatly hindered due to a lack of understanding of disease processes (Pathophysiology).

Symptoms:

- *Irritability when deciphering clinical documentation*
- *Confusion about the disease process*
- *Lack of confidence when speaking to clinical staff*
- *Overuse of search engines to research answers*
- *Loss of productivity when coding*
- *Denials as a result of coding inaccuracies*

Treatment:

Attend our 4-hour workshop this August and immunize yourself against this debilitating disease plaguing thousands of coders.

AUGUST WORKSHOP

Understanding the Disease Process

Diabetes, Hypertension, CAD and Obesity

Get physicians perspective on the most common disease processes: diabetes, hypertension, coronary artery disease (CAD), and obesity. Learn their approach for primary through tertiary prevention and discover how these diseases affect other aspects of patient care. Most importantly, apply your newfound knowledge to code faster and with greater accuracy.

Author: Glade Curtis, MD, MPH, FACOG, CPC, CPC-I, COBGC

Co-Author: Shelly Cronin, CPC, CPMA, CPC-I, CANPC, CGIC, CGSC

Up to 6 CEUs

40+ Cities

$149.95

Find a workshop location near you!

www.aapc.com/pathophysiitis

1-800-626-CODE (2633)

CEU Requirements for Specialty Credential Holders Have Changed

For many months, AAPC has been pondering whether to allow specialty credential continuing education units (CEUs) to also count toward core credential requirements for members who carry both core and specialty credentials. This means that if a Certified Professional Coder (CPC®) obtained CEUs for a particular specialty credential, those CEUs would qualify towards his or her CPC® requirements. Our evaluation process quickly advanced over the past couple of months due to feedback from local chapter visits by our executive team.

AAPC always wants our credentials to be a challenge to obtain and maintain. At some point, however, the requirements go from being a challenge to just burdensome and expensive to those who have multiple credentials with at least one being a specialty credential.

Effective for renewals on or after Oct. 1, AAPC's policy on CEU requirements for members with both a specialty and core credential will change. This change is explained fully on page 50 of this issue of *Coding Edge*.

To summarize, if you own a core coding credential (CPC®, CPC-H®, CPC-P®, CPMA®, or CPCO™) and one or more specialty credentials, CEUs obtained to satisfy specialty credential requirements may also be used toward core credential requirements. There will always be a minimum of 36 hours of unique continuing education required in each two-year period to maintain core credentials; but rather than 48 or 60 hours, you can take 36, or just a few more hours, to satisfy all requirements. We will also continue to communicate what curriculum, webinar, or other training will count toward the specialty credentials AAPC offers.

ICD-10 Implementation Delays

When this letter was written in early June, the final date for ICD-10 implementation had not been determined. The AMA, other specialty physician societies, and state medical societies commented that the delay should be at least two years or, preferably, a halt be put on implementation altogether. America's Health Insurance Plans (AHIP) said that they would prefer no delay but would accept the proposed one year delay. AHIMA essentially said the same, but in much stronger language, preferring no delay. I have been asked many times why AAPC has not commented.

We remain neutral in our view. Physicians are far more impacted by any decision than coders. Coders can learn the codes, but physicians have to learn to document better and in more detail for ICD-10 codes to be applied correctly. This may be difficult for many physicians, due to time pressures and administrative burdens.

No matter when the final date will be, learning the codes should be the last thing you do. It would be unproductive to learn the new code set, go back to using the old code set for a year or more, and then try to remember the new codes after many months of non-use. Please do not waste your and your provider's time and money by jumping too quickly. AAPC offers implementation courses to help prepare your practice for ICD-10 now, but code set learning should be delayed.

Our ICD-10 assessment exam policy will be maintained. You have to pass it and it will be available from one year before until one year after the implementation date. It is critical for all CPCs® to prove their ICD-10 knowledge. If you have other questions, please call AAPC's office and ask us. We have answers.

Sincerely,

Reed E. Pew
AAPC Chairman and CEO

Join Us

INTERVENTIONAL RADIOLOGY, CARDIOLOGY & VASCULAR SURGERY CODING SEMINARS

September 4th-7th
Opryland Hotel
Nashville, TN

ZHealth
PUBLISHING

visit ZHealthPublishing.com or call 1-877-873-9893 for Coding Reference Manuals • Illustrations
Seminar Registration • Webinars • Online Services • Self-Study CEU Programs
and visit AAPC.com for CIRCC exam registration

November 27-30th 2012 Wynn Hotel Las Vegas

NAB Reflects:
Hard Work Breeds Leadership

Conversation turned nostalgic at a recent National Advisory Board (NAB) meeting. When coders reminisce, however, they do not tell the same stories as family members do. Our parents tell stories about walking to school miles away in the snow, barefoot, and uphill both ways. Having been in this field awhile, we have all endured uphill battles of our own, but our stories were about how each of us first entered the medical field.

Humble Beginnings

Looking at **Rhonda Buckholtz's, CPC, CPMA, CPC-I**, career today, you wouldn't suspect that in 1994 she stepped onto her career path as a medical records file clerk in a small primary care office. Within four years, she became coder/biller in the practice. She was recruited to join an ears, nose, and throat (ENT) practice, became certified, was a practice administrator for a large multi-specialty organization, and is now AAPC's vice president for ICD-10 training and education. Her motto for success: "If you want to be the best, you have to work harder than the rest." She stands out in our pack and is willing to take a risk, much to the benefit of our members.

Mia Reddick-Smith's, MBA, CPC, CPC-I, career also began in a medical records department as a tech pulling and copying records requested by payers for audits. "I had to review the requests and extract the pieces of the record needed for the review," Mia said. Today, she is a director of revenue integrity and oversees outpatient/charge description master (CDM) coding and billing to ensure services are billed according to documentation.

If you attended national conference in May, you might have seen **Maria Rita Genovese, CPC**, in the role of receptionist during the NAB opening skit. For Rita, this was a brief return to her roots as a receptionist in a family practice; although, I'm certain in real life she was much more professional. While in this position, she developed the ability to accept criticism, multi-task, and think outside the box. Today, Rita is the director of operations for the Department of Medical Oncology and Infusion Centers at Thomas Jefferson University, in Philadelphia. She attributes her success to the skills she developed as a receptionist, and a positive attitude and work ethic.

Melody S. Irvine, CPC, CPMA, CPC-I, CEMC, CCS-P, CMRS, said, "I started 30 years ago as the hospital operator and admissions clerk. Six years later I was hired at a physician office to answer phones, work front desk, manage referrals, enter data, and ended at a practice as coding administrator and urgent care director for 48 physicians," said Melody. When asked what she believes is the key to her success, she emphatically replied, "Drive, ambition, and believing in myself. I worked hard to progress through the ranks. I never said, 'That's not my job.' I learned every aspect of the practice, and I became very valuable to my employer."

Roles Evolved

Two of your NAB members entered the medical field by volunteering at local hospitals: **Kerin Draak, MS, WHNP-BC, CPC, CPC-I, CEMC, COBGC**, as a candy striper, and **Doris Davis, CPC**, filing charts in a pathology lab and a local medical group. Although both Kerin and Doris' career paths marched forward on the clinical side [Kerin as a nurse practitioner and Doris as a certified medical assistant] both made opportunities for themselves on the business side of medicine as coders, educators, and practice managers.

Not All Roads Begin in Medicine

After working in accounting for many years, **Nancy Clark, CPC, CPC-I**, began looking for a challenge and found medical coding. She said, "I have always challenged myself to do more, to learn more, and to help more." Nancy attributes her success to three things: learn constantly, never accept the norm, and help others. Volunteering with AAPC has made her career complete. She said, "I help students to get interviews. I help coders when I am able to offer guidance on a problem. In return, I expect nothing. I am amazed at how good deeds come back to 'haunt' me." If Nancy needs help, so many people are there for her. She refers to the pay back as the "circle of life," or perhaps, the "circle of coding."

Where to Next?

The NAB's journey down memory lane began with the often-revisited question: "What else can we do to help our newly certified members find jobs?" AAPC Vice President Finance/Business Development Korb Matosich answered this best: "Although we are unable to find jobs for newly certified members, we do help them find jobs by providing education to gain the skills needed in their career, a network of other coders, and a job forum on AAPC's website to locate opportunities in the field."

Use these AAPC resources to help you begin developing and advancing your career. It's hard to be a "newbie," but success is within your reach. We are proof.

Best Wishes,

Cynthia L. Stewart

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

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

LETTERS

New vs. Established Patient Rule Applies to Physicians Only

In reference to "Establish New CPT® Evaluation & Management Rules for 2012" (January 2012, pages 16-18), I am trying to determine how the "new vs. established patient" rule applies to a nurse practitioner (NP).

Specifically, if an NP (but no physician in the group) has seen a patient within the last three years, and the patient then sees a physician, may we report a new patient visit? The rule specifically refers to a "physician." Is the NP considered a "physician" in the context of this rule?

Lora Smith, CPC

As you note, CPT® consistently uses the term "physician" in the context of determining whether a patient should be considered "new" or "established." For example, CPT® instructs:

"Solely for the purposes of distinguishing between new and established patients, professional services are those **face-to-face services** rendered *by a physician* and reported by a specific CPT code(s). A new patient is one who has not received any professional services from *the physician or another physician* of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years." [Italics added for emphasis.]

Although CPT® does not specifically define "physician," it clearly distinguishes between physicians and non-physician practitioners (NPP). For example, the descriptor for immunization code 90460 *Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered* refers to "other qualified health care professionals" as distinct from physicians. No reference to other qualified health care professionals is made with regard to the new vs. established patient rule.

The Centers for Medicare & Medicaid Services (CMS), unlike CPT®, specifically defines a physician as a doctor of medicine or doctor of osteopathy and, within certain limitations, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, and doctor of chiropractic medicine "legally authorized to practice by a State in which he/she performs this function" (see pub. 100-01, *Medicare General Information, Eligibility, and Entitlement Manual*, chapter 5, §70). CMS does not include NPs in the definition of physician, and makes no special concession to include NPs within the new vs. established patient rule as defined for Medicare.

From both a CPT® and CMS standpoint, it appears an NP technically would not count as a physician under the new vs. established patient rule. If an NP within the practice had provided face-to-face services within the previous three years, but no physician had done so, the patient would be "new" to the group.

CT of Abdomen and Pelvis: Take II

I wanted to alert you to a typo in May 2012. On page 44 of "Bundling Rules You Can Take to the Radiologist," computed tomography (CT) abdomen and pelvis without contrast is listed as 74174; however, 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* is CT angiography (CTA) of the abdomen and pelvis. The correct code for CT of abdomen and pelvis without contrast is 74176 *Computed tomography, abdomen and pelvis; without contrast material*.

Teri Bennett, CPC

Good catch, Teri. The information in the article should have specified: Prior to 2011, CT of the abdomen and CT of the pelvis could be reported, and were reimbursed, separately. CPT® 2011 created new codes (e.g., 74176, 74177 *Computed tomography, abdomen and pelvis; with contrast*, and 74178 *Computed tomography, abdomen and pelvis; without contrast material in 1 or both body regions, followed by contrast material(s) and further sections in 1 or both body regions)* that bundle the procedures when performed together.
Later, the article correctly identifies 74174 as appropriate to report CTA of the abdomen and of the pelvis.

2012 CPMA® Class Schedule

Certified Professional Medical Auditor (CPMA®) Educational Training
Prepare for the AAPC CPMA® Credential (16 CEUs)

Review of Regulatory Control Agencies and Pertinent Healthcare Laws, Review of Vital Medical Record Documentation and Guidelines
Learn Scope & Statistical Methodologies, Skill Building Auditing Abstraction, E&M, Surgery and Communication of Results & Education with Providers.

The NAMAS 2-day Certified Professional Medical Auditor (CPMA®) training delivers expert training to coders.
Coders will learn:

- **How to communicate results and educate providers**
- **Valuable skills in auditing abstraction**
- **Scope and statistical methodologies**
- **Instruction on RAC, CERT, MIC and ZPIC audits**
- **Expert training in preparation for AAPC's CPMA®**

Tuition

NAMAS CPMA® Training
$1025 (Regular Cost)
$910 (AAPC & AHIMA Members)

AAPC Exam
$325
Visit www.AAPC.com for details

We will come to you! To request a class in your area call us at 877-418-5564 or email NAMAS@NAMAS-Auditing.com

2012 Class Date	Class Location
7/11 - 7/12	New York, NY
7/24 - 7/25	Seattle, WA
8/1 - 8/2	Orlando, FL
8/9 - 8/10	Great Falls, MT
8/21 - 8/22	Little Rock, AR
9/4 - 9/5	Honolulu, HI
9/5 - 9/6	Denver, CO
9/19 - 9/20	Baltimore, MD

2012 Class Date	Class Location
10/3 - 10/4	Miami, FL
10/15 - 10/16	Knoxville, TN
10/25 - 10/26	Dallas, TX
11/7 - 11/8	San Diego, CA
11/12 - 11/13	Chicago, IL
11/30 - 12/1	Asheville, NC
12/3 - 12/4	Annual Conference
12/12 - 12/13	St. Louis, MO

www.NAMAS-Auditing.com

* Deposits are non-refundable

NAMAS Auditing · 10401 Kingston Pike · Knoxville, TN 37922 · · 877-418-5564 · NAMAS@NAMAS-Auditing.com

By Shannon Sullivan, CPC

Find and Plug Revenue Leaks

Is your practice losing revenue? Answer the following questions to find out.

Q: *Are you collecting co-pays at the time of service? Are patients notified of their co-pays before their date of service? Is there a policy in place for those patients who are unable to pay at the time of service?*

A: The No. 1 way doctors lose money is by not collecting co-pays, co-insurance, and/or deductibles. These amounts should be paid directly from patients at the time of service. Promptly filing claims and collecting co-pays are keys to a profitable practice.

Q: *Is your billing department following up on denials and appealing as necessary? Why are there so many denials?*

A: Failure to verify benefits before patients come to their appointment can lead to excessive denials. This is by far the most common error billing staff makes. Lack of an aggressive follow-up system can cause doctors to lose thousands of dollars annually.

photoby/iStockphoto©FreezeFrame Studio

Two ways to resolve this issue are:

1. Have experienced staff.
2. Have a system in place that tracks accounts receivable (A/R).

Reports need to be run monthly to keep your A/R in check. Don't let your A/R get out of control.

Q: *Are you conducting coding reviews on your claims? Do you offer annual training to your coding staff?*

A: Significant loss of revenue can result if no one is overseeing your coding department.

There is a big difference between those who just submit claims and those who submit clean, accurate claims. Merely leaving a modifier off one of your service codes, for instance, can result in denial of the whole claim. If you lack aggressive denial follow-up, you just lost that revenue.

Q: *Is your staff trained; do they work towards a common goal of the practice; and do all departments communicate?*

A: Undertrained or overwhelmed staff will leave revenue uncollected. Take inventory on who does what in your office and how well they do it. Maybe you should consider outsourcing: Instead of having one person wearing 10 different hats, consider having one dedicated person/company handle your account daily.

Shannon Sullivan, CPC, is owner of Atlantic Billing & Coding, LLC, and founder of the Canton, N.Y. local chapter of AAPC.

By G.J. Verhovshek, MA, CPC

Add-on Codes Describe Mobilization of Splenic Flexure

An AAPC member recently wrote to *Coding Edge* asking, **"If my surgeon mobilizes the splenic flexure while performing partial colectomy, can I report take down separately and, if so, which code is appropriate?"**

The answer is: Yes, you may report mobilization of the splenic flexure separately. The appropriate code depends on the method the surgeon used to accomplish this goal.

If the surgeon performed an open partial colectomy (CPT® codes 44140-44147), with take down of the splenic flexure by corresponding open approach, you may separately report CPT® add-on code +44139 *Mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure*).

If the surgeon used a laparoscopic approach for partial colectomy (44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis*) with laparoscopic mobilization of the splenic flexure, report the latter procedure with +44213 *Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure).*

Colectomy is often necessary for surgical management of colon cancer, and involves removing a section of bowel and the supplying blood vessels proximal and distal to the lesion. The remaining healthy ends of the colon are reattached following excision. Many lesions of the left colon require mobilization of the splenic flexure to allow sufficient tissue length for anastomosis at the upper rectum.

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

Check Ultrasound Diagnostics for Transesophageal Doppler Coverage

Use new HCPCS Level II code G9157 *Transesophageal Doppler used for cardiac monitoring* to bill for esophageal Doppler monitoring, effective Oct. 1, 2012. Medicare will allow G9157 to be billed with either modifier 26 *Professional component* or modifier TC *Technical component* when services are provided in an ambulatory surgical center (ASC), place of service (POS) 24, for operative patients with a need for intra-operative fluid optimization.

Also effective Oct. 1, Medicare contractors will deny:

- Claims lines containing CPT® code 76999 *Unlisted ultrasound procedure (eg, diagnostic, interventional) when billing for esophageal Doppler monitoring.*
- Code G9157 when billed with modifier TC for services provided in an inpatient hospital (POS 21) using claim adjustment reason code (CARC) 125 *Submission/billing error(s)*, remittance advice remark code (RARC) M2 *Not paid separately when the patient is an inpatient* and group code CO *Contractual obligation*.
- Code G9157 when billed in any POS other than 21 or 24 using CARC 58 *Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service* and group code CO.

For complete information, read transmittal R2472CP and *MLN Matters*® article MM7819 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2012-Transmittals.html).

July Outpatient Editor Update

July 2012 updates to the Integrated Outpatient Code Editor (I/OCE), the Centers for Medicare & Medicaid Services' (CMS) system for filing and adjudicating claims paid under the Outpatient Prospective Payment System (OPPS), include a change to bring it in line with correct coding guidelines. The I/OCE is used for outpatient services in hospitals and ambulatory surgical centers (ASCs).

Changes include:

- Effective Oct. 1, 2011, Medicare will apply payment adjustment flag (PAF) 9 (deductible/co-insurance not applicable) to any claim lines when modifier Q3 *Live kidney donor surgery and related services* is present on the line.
- Effective Oct. 1, 2005, the I/OCE deactivates edits described as mutually exclusive to earliest non-archived version. (Mutually exclusive National Correct Coding Initiative (NCCI) edits retroactively merged with code 1/code 2 edits.)
- Effective April 1, 2012, six skin substitute codes are added to the skin substitute logic.

More code changes exist. See www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html for details.

By Barbara Fontaine, CPC

Scholarship Fund Helps Coders in Need

Members reach out to help others realize their career aspirations.

"Can someone help one of my chapter members financially?"

"Is there anything out there to assist one of our members who is not working?"

These pleas and others are heard loudly and clearly by the AAPC Chapter Association (AAPCCA) Board of Directors. We participate in the member forums. We read and listen to your questions, so consequently, the board established the AAPCCA Scholarship Fund recently to help members apply for the financial assistance they need.

Taskforce Builds Framework

The scholarship project was a dream in 2011 by then AAPCCA chair, **Melissa Brown, CPC, CPC-I, CFPC, RHIA**. Brown presented it to the board for consideration and development last year following national conference in Long Beach, Calif. **Judy Wilson, CPC, CPC-H, CPCO, CPC-P, CPC-I, CANPC, CMRS**, chair of the Mentoring Taskforce, also wanted to help chapter members. Wilson and Brown were joined by taskforce committee members **Susan Edwards, CPC, CEDC**; **Melissa D. Corral, CPC**; **Lynn Ring, CPC**; and AAPC employees **Marti Johnson**, **Heidi Larsen**, and **Danielle Montgomery**.

The scholarship fund will help retain membership, encourage chapter participation, and further leadership opportunities by offering assistance to members in times of financial need. The fund will help cover payment towards:

- AAPC membership dues
- Current year coding books through AAPC
- Required CEUs, which would be otherwise unattainable
- Registration cost to attend national or regional conference
- AAPC exam, study guide, or practice exam costs
- Other reasonable special requests (on a case-by-case basis as funds are available)

The Mentoring Taskforce also discussed how the funding would be handled, what the application process would be, and how the applications would be reviewed to determine the actual awards. The scholarship committee will consist of three previous members of the board who have completed service to the board. This committee will be directed by the immediate past chair of the AAPCCA.

Scholarship Fund Launches

The AAPCCA scholarship fund was officially launched at the AAPC 2012 National Conference in Las Vegas, Nev.; and the first donation was presented by AAPCCA for $1,000. The announcement and presentation was made at the AAPCCA officer's Leadership and Training session on Sunday afternoon at conference. Over the next few days, there was a flurry of giving as people passed the AAPCCA table and donated. At the end of conference, the total donated by attendees was $2,455, which was matched by AAPC Chairman and CEO **Reed Pew**, making the end-of-conference total $5,910. What a great start to the new project!

Apply Online

Applications may be submitted by members for themselves or on behalf of another member who they feel is in need. Completed applications should be submitted online or via email to scholarship@aapcca.org. If the application is sent on behalf of someone else, please have the member requiring assistance sign the application to verify the information is accurate before submitting it to the AAPCCA. Scholarship application forms are available online at www.aapc.com/MemberArea/Chapters/scholarship.aspx.

Pay It Forward

AAPC and the AAPCCA hope the scholarship fund will be adopted by all AAPC chapters. We want all members to feel they helped pay it forward by assisting someone in their own profession in tough times. We encourage members to talk to their chapter officers and to consider this project important enough to include in chapter budgets and schedules in the coming years. Make the scholarship fund a chapter or solo project.

Donations can be made payable to the AAPCCA Scholarship Fund and sent to:

AAPCCA
Scholarship Fund
2480 South 3850 West Suite B
Salt Lake City, UT 84120

With help from us all, we can make a difference in the lives of our fellow members.

Barbara Fontaine, CPC, serves on the AAPCCA Board of Directors and is business office supervisor at Mid County Orthopaedic Surgery and Sports Medicine, a part of Signature Health Services. She served on several committees before becoming a local chapter officer. In 2008, she earned the St. Louis West, Mo. local chapter and AAPC's Coder of the Year awards.

By Angela Jordan, CPC

Reporting CEUs Accurately

Have you ever arrived late to a local chapter meeting or a seminar? Or, perhaps you received an emergency text or call from your manager during a workshop that required you to leave early? If so, did you report the continuing education units (CEUs) accurately?

AAPC members are awarded one CEU per hour of coding instruction. CEUs for local chapter meetings or events should be adjusted by the president or education officer for any member who is not present for the entire educational session. This information can be located in the *Local Chapter Handbook* at http://static.aapc.com/ppdf/LC_Handbook2.pdf, in chapter 7, section 8.1.2.

If the speaker finishes early because there is no additional education material, CEUs must be adjusted for all members present and the Local Chapter Department should be notified (chapter 5, sections 7.2.1 and 7.2.1.1 of the *Local Chapter Handbook).*

Likewise, if you arrive late or leave early, adjust your CEUs accordingly when entering them into the CEU Tracker. This can be done by answering "No" to the question, "Do you have the index/catalog number?" This allows you to manually enter all of the information and correctly report only the CEUs you actually earned.

CEU Tracker, available at www.aapc.com

As a member, you should follow this policy to "Uphold a higher standard"—and it's the right thing to do.

By G.J. Verhovshek, MA, CPC

Intrafacet Implant Doesn't Bundle Open Approach Arthrodesis

Clarify confusion by knowing when to bill separate procedures.

Category III CPT® codes 0219T-0222T describe a minimally invasive technique for fusion of the spinal facet joints, wherein bone or a device is introduced (percutaneously or by "open" incision) into the facet joint and placement is confirmed using imaging. Discussing these codes, the article "Spine Reimbursement Sees a Major Impact" (April 2012 *Coding Edge*, pages 22-24) stated:

"… 0220T-0222T include fusion as well as instrumentation, grafting, etc. Prior to this year, these procedures have been coded separately in addition to 22610 and 22612; in 2012, the new codes cover everything."

This above information was derived from American Medical Association (AMA) guidelines. CPT® code descriptors for 0219T-0222T specify that placement of unilateral or bilateral posterior intrafacet implant(s) includes imaging and placement of bone graft(s) or synthetic device(s). The AMA's *CPT® 2012 Changes: An Insider's View* also instructs, "An exclusionary parenthetical instruction … preclude[s] the use of instrumentation, open approach arthrodesis, and use of spine allograft in addition to the new codes, when performed at the same level."

Simply stated, 0219T-0222T bundle any associated bone grafting, instrumentation, and imaging at the same level, either unilaterally or bilaterally.

Extensive Arthrodesis Calls for More Granular Coding

Although placement of intrafacet implants can be a minimally invasive procedure, several *Coding Edge* readers have pointed out that placement of intrafacet implants can also be performed at the same level with more extensive open arthrodesis procedures. In such a case, the open approach arthrodesis (e.g., 22600-22614) is not bundled to the Category III codes 0219T-0222T. Instead, if an open approach is used to perform a posterolateral fusion and placement of intrafacet implants, you would report open approach arthrodesis, rather than 0219T-0222T, as the primary procedure. You may report instrumentation and bone grafting separately, when performed, with an open approach arthrodesis.

For example, a surgeon performs anterior lateral interbody fusion (ALIF) at L4-L5 using a morsalized allograft with placement of PEEK cage. He also documents posterolateral lumbar fusion at L4-L5 and L5-S1 with facet fusion, local bone autograft, and spinous process clamping. Proper coding is:

22558 *Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar* for ALIF at L4-5

+22851 *Application of intervertebral biomechanical device(s)(eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)* for the PEEK cage at L4-5

+20930 *Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)* for the morselized allograft

22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* for the posterolateral lumbar fusion at L4-5, which includes facet fusion (Some payers may require modifier 51 *Multiple procedures* with this code.)

+22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)* for the posterolateral fusion at L5-S1

+20936 *Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)* for the local bone autograft

22899 *Unlisted procedure, spine* for the spinous process clamping

Because the facet fusion is inclusive of the posterolateral arthrodesis (22614), you would not report 0221T *Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; lumbar.*

In a Nutshell

When the surgeon performs minimally invasive placement of intrafacet implants without open approach arthrodesis, report 0219T-0222T, as appropriate. Do not report imaging, bone grafts, or instrumentation separately at the same levels.

When the surgeon places intrafacet implant(s) during open arthrodesis, report the open arthrodesis as primary, along with any necessary bone grafting and the instrumentation placement. Do not report 0219T-0222T in addition to the open arthrodesis. CE

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

CodingWebU.com™

Providing Quality Education at Affordable Prices

Tired of CD-Rom Courses that are out-of-date as soon as you take them?
Tired of Audio Conferences where you cannot learn at your own pace?
Tired of Online Courses you go through once and cannot access again?
If so, CodingWebU.com is your answer!

We are the only program that provides interactive training incorporating audio, text and graphics to ensure you comprehend the information being taught. You will receive live updates as codes change and content is added. You always have access to the most current information, even if you purchased the course three years ago.

2012 Coding Scenarios ARE NOW AVAILABLE!!!

2011 Annual CEU Coding Scenarios are also Available

Over 60 Courses Approved for CEUs starting @ $30

- Anatomy
- Medical Terminology
- Physicology
- ICD-10
- Chart Auditing
- RAC
- CPT® & ICD-9 Updates
- E/M and OB/GYN
- Pain Management Injections
- Emergency Department Coding
- Interventional Radiology
- Burns, Lesions, and Lacerations
- Billing & Reimbursement
- General Surgery Coding
- Phys. Pract. Revenue Mgm't
- Advanced Beneficiary Notices
- Specialty Coding
- Modifiers
- Sleep Disorders
- Meaningful Use Compliance
- E|M Coding
- EHR
- ...and more

We offer group discounts and reporting for larger customers.
We can also create or host custom courses for your employees.

CALL NOW to order your 2013 Coding Books!

(484) 433-0495 www.CodingWebU.com

AAPC CEU APPROVED · AMA AMERICAN MEDICAL ASSOCIATION · contexo | media · INGENIX · Find us on Facebook · Follow me! · LinkedIn

By Susan M. Edwards, CPC, CEDC

Answer Your DME Questions

Be sure the item or service is covered; and if it's not, here's what you do.

Correct coding and billing for durable medical equipment (DME) raises many questions, such as:

- What constitutes DME?
- Besides the order and physician signature, what other information do I need to submit a claim?
- Are there modifiers?

To shed some light on ambiguous areas, we'll answer these questions and more.

What Is DME?

Per Centers for Medicare & Medicaid Services (CMS) guidelines, DME is "medically necessary durable medical equipment, prosthetics, orthotics, and disposable medical supplies (DMEPOS), which includes oxygen and related supplies, parenteral and enteral nutrition, and medical foods."

DME is also medical equipment that:

- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Is generally not useful to a person in the absence of illness or injury
- Is appropriate for use in the home
- May include a rigid or semi-rigid device
- May be designed to support weak or deformed body part by eliminating motion
- May be used to immobilize a part to decrease pain and inflammation
- May be rented or purchased

What Do I Submit with Claims?

Providers must submit DME claims in accordance with Healthcare Common Procedural Coding System (HCPCS) Level II coding guidelines and national and local coverage determinations (NCDs and LCDs). Providers may only bill for the actual number of medical necessary units dispensed or delivered to a patient, regardless of the number of units allowed by policy and/or prior authorization.

Orders are required for any DME equipment to be covered under Medicare. To bill Medicare for DME, the ordering physician must be a Medicare enrolled physician.

Requirements on the orders include:

- Dispensing order
- Description of item
- Name of beneficiary
- Name of ordering physician and signature
- Date of order
- Diagnosis
- Quantity delivered
- Item brand name and serial number (if not custom)

Documentation should include detailed descriptions of the item, as well as any accessories and upgrades that will be used. Written orders for custom fabrications must specifically state "custom fabrication," or the brand name being used. Custom fabrication involves more than trimming, bending, or making other modifications to a substantially prefabricated item. Prefabricated items are factory processed without a patient in mind, but may be altered to fit the patient.

Products and services must be medically necessary, safe, and appropriate for the course and severity of the condition using the least costly and equally effective alternative to meet the recipient's needs. For all DME items, refer to your state's Medicare policy.

To support medical necessity, include chart notes, surgery notes, and all supporting documentation for the product. You will need to verify that:

- The patient is eligible and meets the coverage criteria.
- Ask the patient about the items being dispensed. For example, "Have you had a wheelchair before?" or, "Do you receive any diabetic supplies from anyone else right now?"
- There is a supporting diagnosis.
- The beneficiary has signed and dated the forms.
- The physician has signed and dated the forms.
- The physician has provided his or her National Provider Identifier (NPI) number.

Note that some DME services or items will require prior authorization. It is critical to submit complete and accurate clinical documentation on prior authorization requests.

When a claim is received, Medicare will determine if the ordering/referring provider is required for the billed service. If the

Documentation should include detailed descriptions of the item, as well as any accessories and upgrades that will be used.

Ask the Patient to Sign an ABN if Coverage Is in Doubt

When ordering DME, determine whether you should ask the patient to sign an Advanced Beneficiary Notice (ABN). The ABN is a standard form to inform a patient that Medicare may deny coverage for a recommended or desired item or service. It explains why Medicare may deny the item or service, provides a cost estimate for the item or service, and notifies the patient of his or her responsibility to pay for the non-covered item or service if he or she chooses to receive it. In many cases, a provider cannot seek payment from the patient for unpaid Medicare services if he or she did not properly issue an ABN.

The ABN must be verbally reviewed with the beneficiary or his or her representative and any questions raised during that review must be answered before the patient signs and dates the ABN. CMS requires the provider present the ABN "far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice." A copy of the completed, signed form must be given to the beneficiary or representative, and the provider must retain the original notice on file for seven years.

When filing your claim, apply modifier GA *Waiver of liability statement issued as required by payer policy, individual case on file* when the provider believes the service is not covered and the office has a signed ABN on file.

Modifier GY *Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit* applies when Medicare excludes the item or service from coverage. When you report modifier GY, Medicare will generate a denial notice that the beneficiary may use to seek payment from secondary insurance, for instance.

If the provider fails to issue an ABN for a potentially uncovered service, append modifier GZ *Item or service expected to be denied as not reasonable and necessary to the claim.* This indicates the provider cannot hold the patient financially responsible if Medicare denies the service, but will reduce the risk of fraud or abuse allegations for claims deemed "not medically necessary."

The ABN CMS-R-131 form and instructions may be downloaded from the CMS website: www.cms.gov/BNI/02_ABN.asp.

provider is not on the claim, Medicare will not pay. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in Medicare Provider Enrollment, Chain, and Ownership System (PECOS) and eligible to order and refer.

DME Modifiers

Modifiers are frequently used on DME claims. The most common include (Note: These are not the full descriptions.):

RT/LT – Right/left

NU – New equipment

GY – Non-covered item

KX – Required for knee and ankle-foot orthoses

RR – Rental

UE – Purchase of used equipment

CG – May or may not have a specific LCD in place

GA – Does not meet medical necessity and ABN signed

GZ – Does not meet medical necessity and ABN not signed

GY – Item statutorily not covered

RA – Replacement of DME, orthotic, or prosthetic item

EY – No physician order

Use a Form to Be Sure You've Got All Relevant Information

Perhaps the best way to ensure you've documented all the necessary information is to use a specialized DME intake form. You can find a sample DME Intake Form at Noridian Administrative Services (NAS): www.noridianmedicare.com/dme/forms/docs/intake_form.pdf.

Any person in the office can use the form to ensure all the right questions are asked.

Lastly, remember to always check your DME Medicare administrative contractor (MAC) websites often for LCD revisions. Educating your physicians of documentation requirements and coverage guidelines will help you as the coder/biller make submitting claims for DME an easier process.

Susan Edwards, CPC, CEDC, is a coding specialist at Copley Hospital in Morrisville, Vt. She is the president of the Newport, Vt. chapter, and she teaches Medical Terminology at the local adult learning center. Ms. Edwards is Northeast region one representative for AAPCCA, and secretary on the Board of Directors. She is also on the AAPC Ethics Committee.

By Ken Camilleis, CPC, CPC-I, CMRS

CPT® +15777: Biologic Implant Procedures

Four guidelines lead the way for accurate coding.

Takeaways:

- Code +15777 was added to CPT® 2012 to better report biologic implants.
- Distinguish biological implants from other materials.
- Know the primary codes.
- Report supplies separately.

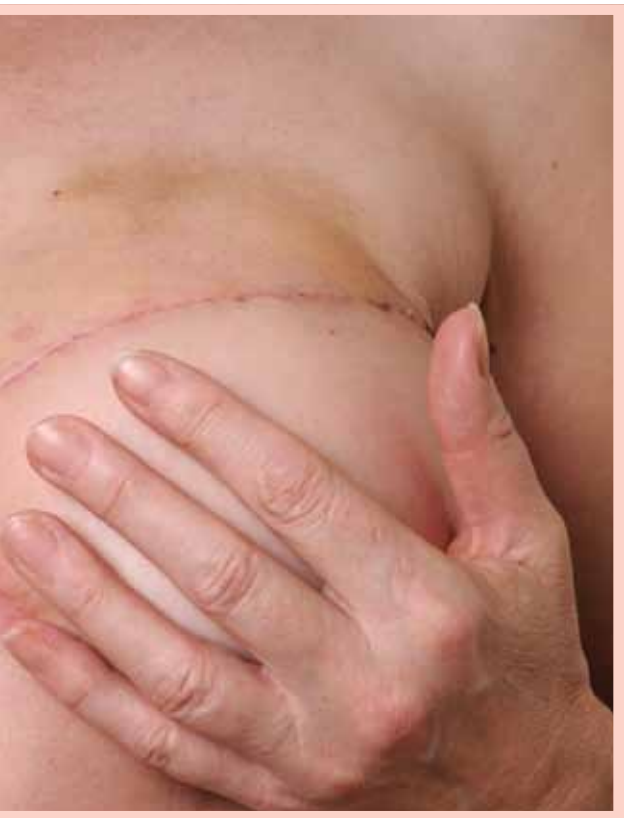


photo by iStockphoto©Les Palenik

Add-on code +15777 *Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)* was added to the "Other Flaps and Grafts" category of the Integumentary System, Repair subheading in CPT® 2012 to describe the implantation of a biologic implant, such as donor skin or nonhuman skin substitute, for soft tissue reinforcement. Application of this code is fairly straightforward, but there are a few guidelines to keep in mind.

1. Distinguish Biologic Implants from Topical Applications, Mesh, and Other Materials

Code +15777 applies specifically for placement of a biologic implant (such as acellular dermal matrix) for soft tissue reinforcement or to correct a soft tissue defect (for instance, in the breast or trunk) caused by trauma or surgery. Biologic implants are usually porcine or allogenic grafts that have been decellularized to reduce the possibility of the body rejecting the implant.

Code +15777 is distinct from 15271-15278, which are intended to report topical applications of skin substitute grafts. You may report placement of biologic implant with skin graft when the procedure is done at the same operative session; however, do not report +15777 in place of 15271-15278 for topical skin substitutes.

Do not use +15777 to report placement of mesh, as described by either +49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* or +57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)*. Per CPT® 2012 instructions, when incisional/ventral hernia repair or repair of pelvic floor defect is involved, use +49568 or +57267, as applicable, not +15777.

Finally, for repair of anorectal fistula with plug, use 46707 *Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])*, rather than +15777.

2. Know Which Primary Codes Apply

As an add-on procedure, +15777 may never be coded alone, and must always accompany an appropriate primary procedure. Generally accepted primary (and associated add-on) procedures for +15777 include autografts/allografts and skin substitute procedures of the trunk (15040-15278), as well as breast repair and reconstructions (19316-19396).

3. Append Modifier 50 for Bilateral Breast Procedures

When biologic implant is used bilaterally for tissue repair during breast reconstruction, CPT® 2012 allows you to report +15777 with modifier 50 *Bilateral procedure*.

4. Report Implant Supply Separately

Code +15777 describes placement of the implant only; it does not include supply of the implant. Per CPT® instructions, you may report supply of the implant separately (e.g., Q4116 *AlloDerm, per sq cm*). Most often, the facility (rather than the operating surgeon) will bear the cost of supplying the implant.

Generally accepted primary (and associated add-on) procedures for +15777 include autografts/allografts and skin substitute procedures of the trunk (15040-15278), as well as breast repair and reconstructions (19316-19396).

If the surgeon does not supply the implant, he or she cannot bill for it.

Clinical Scenarios Clarify Code Application

Case 1: A 58-year-old female undergoes a unilateral total (simple) mastectomy with immediate placement of a tissue expander for reconstruction. An 81 sq cm piece of acellular dermal matrix is sutured to the subpectoral pocket rim and the skin flaps are brought together. The skin is closed primarily. Correct coding is:

19303 *Mastectomy, simple, complete*

19357 *Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion*

+15777 (for implantation of acellular dermal matrix)

Case 2: A 34-year-old woman was involved in a motor vehicle accident and suffered deep cuts to her neck from windshield glass. She required an acellular dermal allograft of a surface area totaling 167 sq cm. Correct coding is:

15277 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children* for first 100 sq cm.

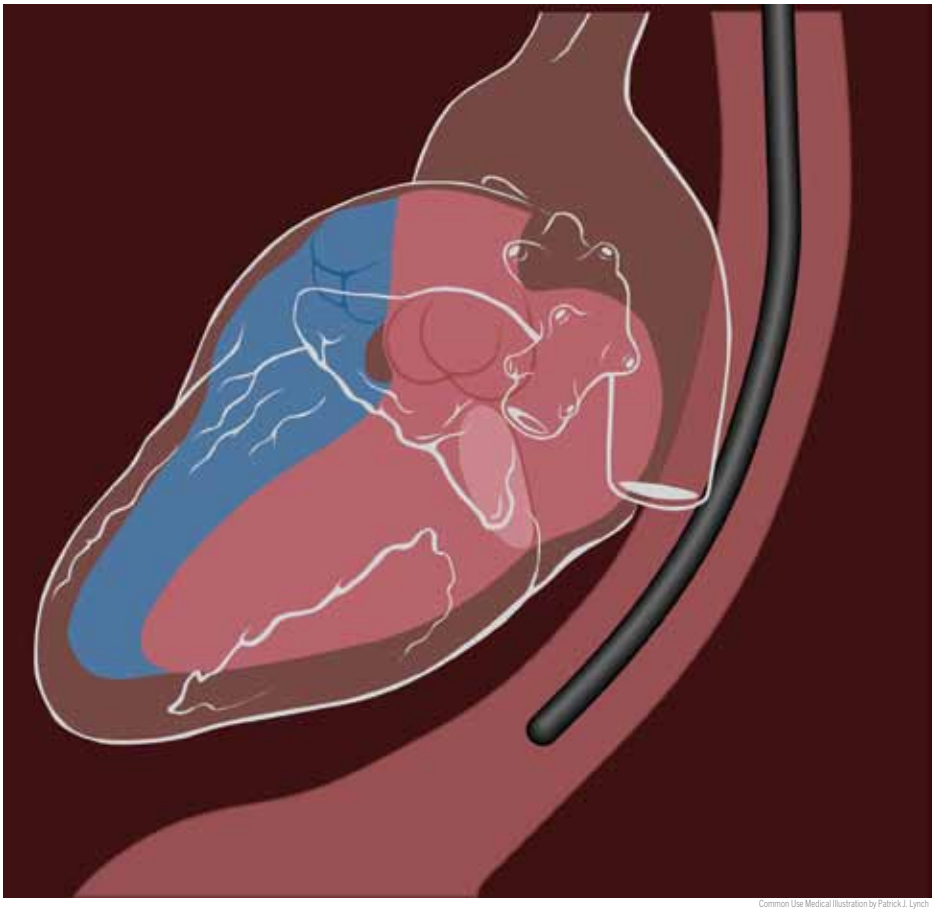
+15278 *each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* for remaining 67 sq cm.

In this case, no dermal implant is used or coded; rather, topical application of skin substitute graft codes are appropriate.

Kenneth Camilleis, CPC, CPC-I, CMRS, is a medical coding and billing specialist whose present focus is coding education. Mr. Camilleis is a full-time Professional Medical Coding Curriculum (PMCC) instructor and part-time educational consultant. He is the member development officer and is on the ICD-10 Advisory Committee for his local chapter.

By Judy A. Wilson, CPC, CPC-H, CPCO, CPC-P, CANPC, CPC-I, CMRS

Documentation Is Key for TEE and OLV



Common Use Medical Illustration by Patrick J. Lynch

Reporting these anesthesia services depends on understanding physicians' notes and bundling rules.

A transesophageal echocardiogram (TEE) uses an ultrasound transducer positioned on an endoscope and guided into the patient's esophagus to visualize the heart's valves and chambers without interference from the ribs or lungs.

An anesthesiologist may use TEE as a diagnostic tool to establish conditions such as myocardial ischemia or cardiac valve disorders. In such cases, you may bill the TEE separately in addition to the anesthesia. You must append modifier 59 *Distinct procedural service* to the appropriate TEE code, or National Correct Coding Initiative (NCCI) edits will automatically bundle the TEE with the anesthesia.

You should report TEE using either 93312 *Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report* for a basic study, or 99315 *Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report* for a congenital study. It is important to distinguish between the procedures because reimbursement is higher for a congenital study.

To identify a congenital study, look for documentation stating "congenital," and/or for a diagnosis of congenital anomalies, such as 745.10 *Complete transposition of great vessels.*

Apply Modifiers, Add-ons, for Complete Coding

When reporting TEE studies, don't forget modifier 26 *Professional component*. This modifier always must be applied in the facility setting, or whenever the anesthesiologist performing the TEE does not own the equip-

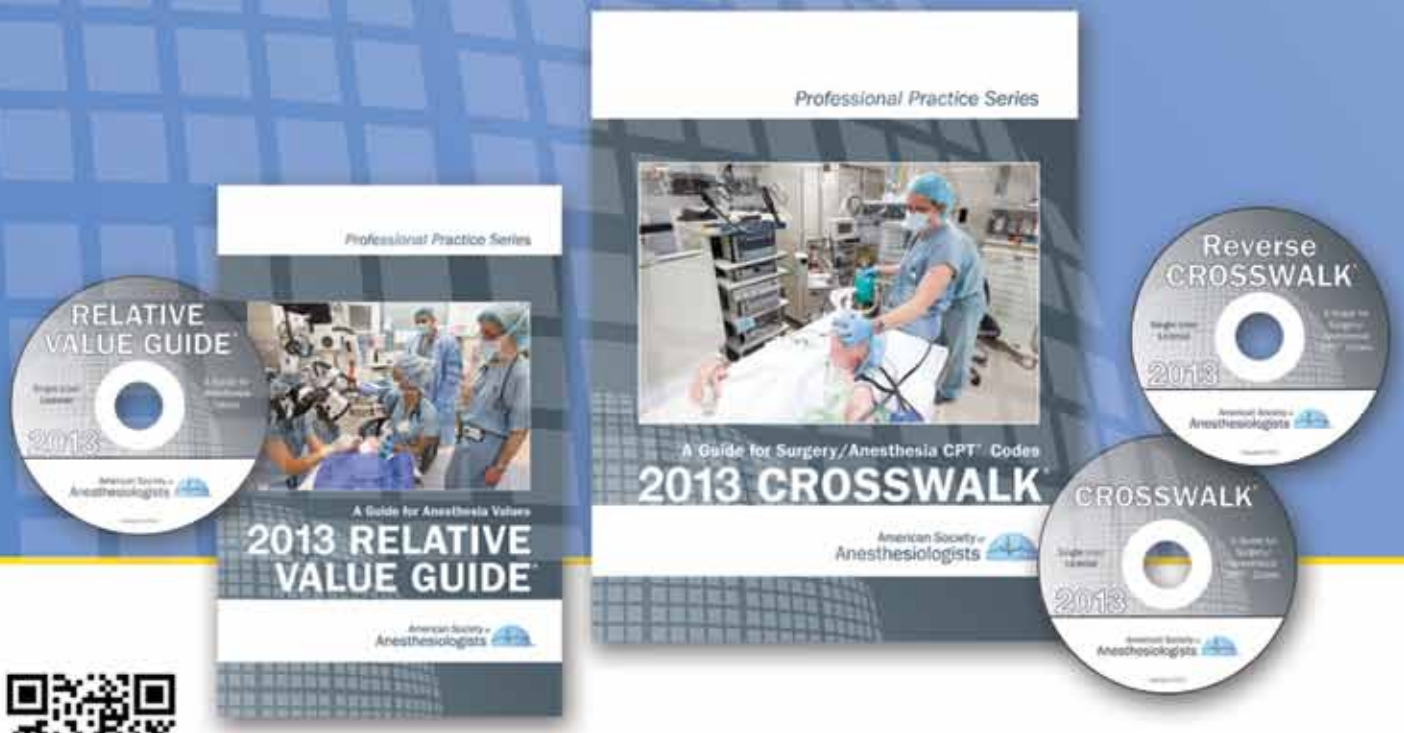
Anesthesia Coding Resources

Pre-Order 2013 Editions

- **2013 Relative Value Guide®: A Guide for Anesthesia Values**
- **2013 CROSSWALK®: A Guide for Surgery/Anesthesia CPT® Codes**

Accurately report, submit compliant claims, and obtain proper payment by purchasing the premier coding resources developed by the authority in anesthesia – the American Society of Anesthesiologists (ASA).

Take advantage of substantial savings with multi-user and multi-book pricing. For more information and to order, visit **www.asahq.org/Coding13** and use Promo Code: Edge or call ASA at **847-825-5586**.



goo.gl/Eb0r6

American Society of Anesthesiologists

When reporting TEE studies ... modifier 26 *Professional component* ... always must be applied in the facility setting, or whenever the anesthesiologist performing the TEE does not own the equipment used to conduct the study.

ment used to conduct the study. The anesthesiologist must perform the placement, image acquisition, and interpretation (including a written report) to correctly bill for these services.

Add-on codes may also be applicable with TEE, such as those for pulse wave/continuous wave (PW/CW) Doppler (+93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete*) or color flow Doppler (+93325 *Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)*). Doppler procedures may be performed at the request of the surgeon, usually for valve disorder.

Other, additional procedures that may be performed with TEE include 76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation*, or 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation*. Three-dimensional rendering allows for more complete visualization of structures, and may be ordered because of intrathoracic organ abnormalities found in more conventional imaging.

As with the TEE codes, you must append modifier 26 to Doppler and 3D rendering codes when the service is provided in a facility setting (which will most likely be the case), or anytime the billing physician does not own the equipment necessary to provide the service.

Coding Example: The anesthesiologist documents a coronary artery bypass graft (CABG) x 1, along with a basic study TEE with PW/CW, color flow Doppler, and 3D rendering without independent workstation. Proper coding is:

- 00567 *Anesthesia for direct coronary artery bypass grafting; with pump oxygenator*
- 93312-26-59 for the basic study. Modifiers 59 and 26 are appended to indicate this as a separate procedure, distinct from anesthesia, and that only the professional portion of the service is being billed.
- +93320-26 to describe the PW/CW Doppler. Because +93320 is an add-on code, modifier 59 is not required; however, modifier 26 is required to indicate that the anesthesiologist is providing only the professional portion of the service.
- +93325-26 is reported in addition to 93312 for color flow Doppler, professional component.

Takeaways:

- A transesophageal echocardiogram (TEE) is a diagnostic and monitoring tool used to visualize heart valves and chambers, often during surgery.
- One lung ventilation (OLV) is a technique used to keep one lung ventilated while services are performed on another.
- Documentation is key to being properly reimbursed for procedures, which are usually performed by an anesthesiologist.

TEE for Monitoring Isn't Separately Reportable

When an anesthesiologist performs a TEE for monitoring purposes only, you will not receive separate reimbursement for the TEE in addition to any anesthesia service provided.

TEE monitoring of ventricular function is used intra-operatively in select high-risk patients and, if performed by the anesthesiologist during surgery, is included in the reimbursement of the anesthesia service. You would not separately report 93318 *Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real-time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis*.

One Lung Ventilation and VATS

One lung ventilation (OLV)—the ability to ventilate one of a patient's lungs, allowing the other one to collapse—is used when performing video-assisted thoracic surgery (VATS), lobectomy, or Maze procedures to treat atrial fibrillation, to name a few examples. You'll want to be sure that your anesthesiologist is properly documenting OLV—and that you, the coder, are able to recognize it in the anesthesia record—because OLV has a higher base value than non-OLV procedures.

For example, 00540 *Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified* is a 12 base, but 00541 *Anesthesia for thoracotomy procedures involving lungs, pleura, dia-*

The anesthesiologist must perform the placement, image acquisition, and interpretation (including a written report) to correctly bill for these services.

phragm, and mediastinum (including surgical thoracoscopy); utilizing 1 lung ventilation, which includes OLV, is a 15 base. This three-base difference matters for reimbursement.

Coders should always try to bill directly from the anesthesia record (rather than from a charge voucher, for instance). OLV will most often be documented with a "down arrow" (showing the lung has been deflated), followed by an arrow up when the lung is re-inflated. Because most anesthesiologists won't write out "OLV," it's important for coders to recognize this shorthand documentation.

Understanding when and why other services might be performed by the anesthesiologist will enable you to help your physician document necessary information on the anesthesia record. In return, you will be able to code correctly and your physician will see more reimbursement.

Judy A. Wilson, CPC, CPC-H, CPCO, CPC-P, CANPC, CPC-I, CMRS, has been coding/billing anesthesia for over 30 years. For the past 19 years she has been the business administrator for Anesthesia Specialists, a group of nine cardiac anesthesiologists at Sentara Heart Hospital. Ms. Wilson started the AAPC Virginia Beach local chapter and is an active member. She teaches medical coding classes in Tidewater, Va. Ms. Wilson has served on the AAPCCA Board of Directors since 2010 and was treasurer in 2011. She has presented at several AAPC regional conferences and the national conference in Las Vegas.

AAPC

CHICAGO HYATT REGENCY
3-Days | 14 CEUs

CHICAGO
2012 AAPC REGIONAL CONFERENCE

REGIONAL CONFERENCE

CHICAGO | OCT. 25-27, 2012

Early Bird Ends July 20th

~~$350~~ **$325**

Come to the windy city for AAPC's Regional Conference and join members of AAPC's National Advisory Board, AAPCCA Board of Directors, vendors, and hundreds of your friends and colleagues for networking and educational events.

www.aapc.com/regional2012

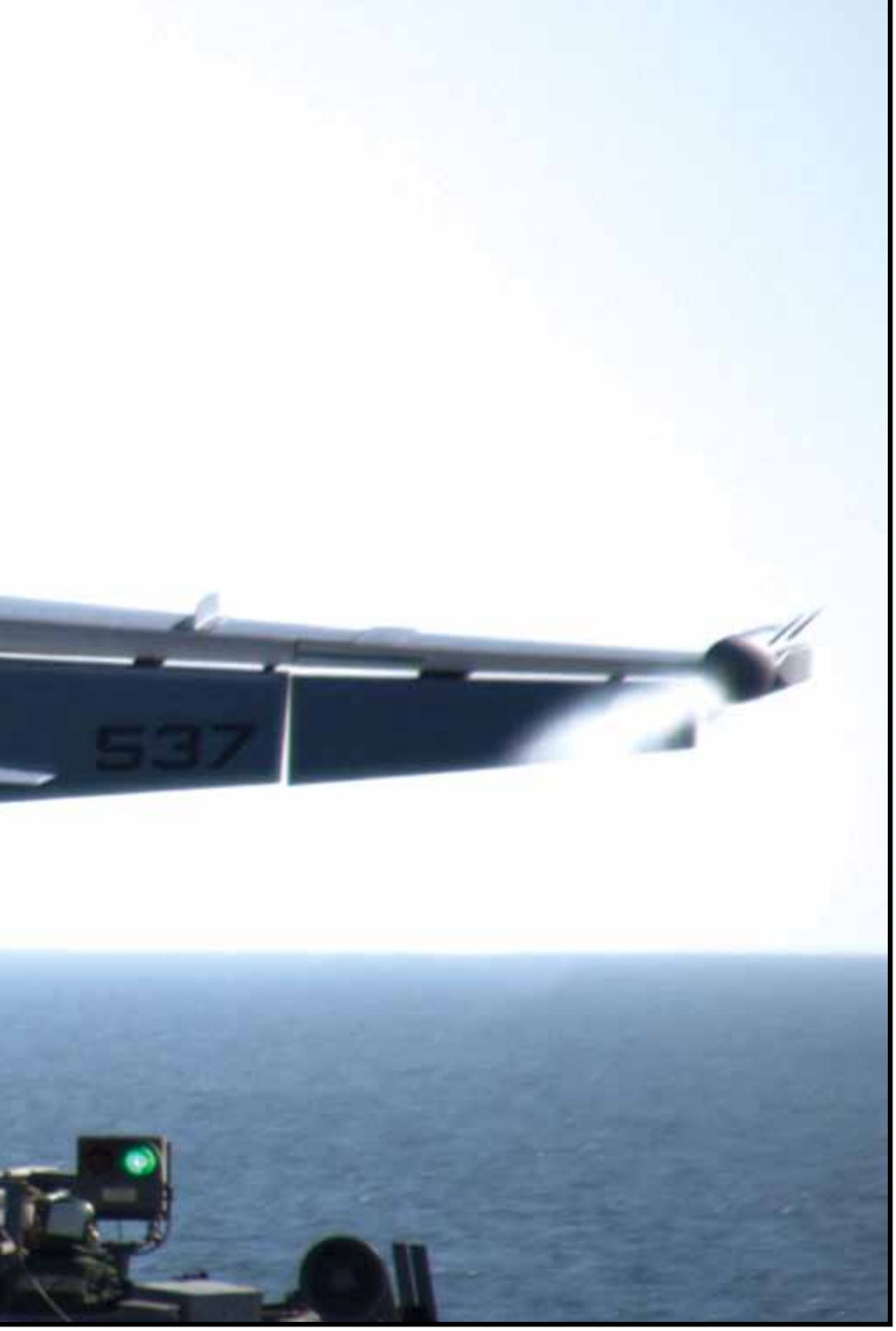
AAPC

Photo: Courtesy of Dr. David Dunn

Take a Doctor's Tour on the U.S.S. George H.W. Bush

American pride swells as future AAPC leader boards a Nimitz class nuclear aircraft carrier.

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



F-18 Super Hornet catapult take-off.

Self-contained Floating City

The U.S.S. George H.W. Bush, commissioned in January 2009, is the newest of the 10 Nimitz class nuclear aircraft carriers and is deployed with other tactical ships, including submarines. The ship is designed for a 50-year service life, with two nuclear reactors to be refueled only once. It is 1,092 feet long with a top speed of over 30 knots. The crew of 5,000 is comprised of approximately 3,000 ship's company and 2,000 air wing troops. The carrier holds three months' worth of food. Periodically, U.S. tankers approach it to load jet fuel and haul off trash. With a flight deck that covers 4.5 acres, it can accommodate more than 70 aircraft. Some are in hangers beneath the deck and are moved to and from the deck by large freight elevators.

Photo: US Navy

Ten were chosen to take a ride, learn military procedures, and observe personnel on the U.S.S. George H.W. Bush aircraft carrier as part of the "Distinguished Visitors (DV) Program." Among them was AAPC National Advisory Board (NAB) president-elect, **David B. Dunn, MD, FACS, CPC-H, CIRCC, CCC, CCS, RCC**. Here is his account of the once-in-a-lifetime experience:

Jan. 25, 2012 – Anticipation Builds

We headed towards Norfolk, Va., departing from Nashville, Tenn. Anticipation grew as I joined a group of fathers from my son Alex Dunn's school, Montgomery Bell Academy (MBA). Nashville had been selected as one of the cities in a program to promote the Navy. I arrived the night before we were to embark and stayed in a hotel adjacent to Naval Station Norfolk. Second only to the naval base in San Diego, it's the largest Naval base in the United States.

Jan. 26, 2012 – Geared up and Ready for a Full Day

In the morning, the other MBA dads and I were picked up by Lt. Phillip Rossi and shuttled to the staging area on the base. We were quickly issued essential gear: helmets, goggles, and ear protection. Next, we boarded a Grumman C-2 Greyhound, which is a carrier on-board delivery (COD) plane critical to keeping the carriers operating at sea. They transport sailors, supplies, patients, and equipment within a 1,000-mile range, providing logistical support to carriers from bases around the world.

From 105 to 0 MPH in 2 Seconds

We had been in the air for about an hour when I spotted the impressive wake of the U.S.S. George H.W. Bush in the Atlantic Ocean. When we were cleared for landing, we approached the carrier deck,

sitting backwards. We had a few seconds warning from the crew, who frantically waved their hands. We made an "arrested landing" at 105 mph, as the plane's tail hook caught one of the three arresting cables bringing us down to 0 mph in two seconds, and screeching to a stop in 300 feet of landing space. There is no room for error. Just prior to landing, the pilot guns the engine so if all three wires are missed, they can take off and circle for a repeat attempt—known as a "bolter." I'm sure the pilots who have to resort to a bolter are kidded at dinner afterwards.

On Board U.S.S. George H.W. Bush

We exited the C-2 Greyhound and were greeted by the commanding officer, Capt. Brian Luther, who led us to his office/greeting area for introductions and itinerary review. We also met the ship's executive officer, Capt. Pennington. He told us of the young aviator, George H.W. Bush, who was shot down during World War II near Chichi-Jima in the Pacific and rescued by a submarine, The U.S.S. Finback, who caught it on video. Mr. Bush subsequently attended Yale and started a lifetime in politics, holding posts as a congressman, CIA director, ambassador to the United Nations, and 41st president. We were served warm chocolate cookies and scanned the many photos of the Bush family. Next, we met the handler, Lt. Cmdr. Rancourt, who checks and maintains the locations of all aircrafts on the flight deck. Despite the amazing, cutting-edge technology, plane locations are maintained as they have been for half a century, by manually placing mini-cutouts of the planes on a "Ouija board."

The day was filled with clear skies, deep blue water, and smooth sailing. During the two days we were there, the carrier personnel conducted aviator qualifications, so we witnessed a long series of catapult launches, touch-and-goes, and arrested landings of F-18 Super Hornets. These are Boeing twin-engine jets that travel at Mach 1.8+ (or more than 1,335 mph), with a 1,275 nautical-mile range.

I am enamored by jets. I've seen the Blue Angels perform air shows in the Nashville area and practice at the Naval Air Station in Pensacola, Fla. I've been to the Pensacola Naval Museum. None of these things prepared me for the next adventure.

From 0 to 187 MPH in 2 Seconds

We were led by a safety officer to an area immediately adjacent to the start of the steam-driven catapult launch where F-18 Super Hornets were hooked to the launcher and, with only 200 feet of runway space, propelled from 0 to 187 mph in two seconds. Standing a few feet away from the wings of these amazing jets, the power/force, heat, and steam I felt was indescribable. I took hundreds of pictures to capture the surreal experience.

Safety First

Although the flight deck was an incredibly dangerous environment, the protocols in place were impressive. Prior to launch, rescue helicopters continuously circled the carrier in the event a pilot needed to be rescued. Fire crews remained on deck in full gear. Crewmen wore color-coded vests based on their specific jobs. Nearby, safety officers

Distinguished visitors are geared up (Dr. Dunn is second from right).

Photo: US Navy

During the two days we were there, the carrier personnel conducted aviator qualifications, so we witnessed a long series of catapult launches, touch-and-goes, and arrested landings of F-18 Super Hornets.

Photo: Courtesy of Dr. David Dunn

made sure no one crossed the safety mark on deck without first asking permission. We looked up to see the extensive radar and communication equipment, as well as the control tower.

We were then led aft to observe the landings. Standing just behind the safety mark on deck, we watched as the jets made their final approach. It was amazing how close they descended over the rear deck, with the tail hook dangling to engage one of the three arresting cables and complete the landing. Across from us a group of experts rated the performance of each Navy pilot on his or her landing.

Complete Tour

After observing the flight deck operations, we returned to Capt. Luther's area to let the adrenaline wear off. He told us the environment on the ship qualified it to be the "ultimate team sport." Even though he had dreamed of being an astronaut as a child, he said he felt he had the coolest job in the world. With so many decks connected by vertical ladders, I soon understood why Capt. Luther called the ship "the most expensive stair climber on the planet."

We toured almost the entire ship, except for the nuclear reactor area below. After a fabulous lunch, we were brought to the command tower and each took a turn sitting in the commanding officer's chair, where we observed flight operations. On the tour I was struck by the attitude, professionalism, and happiness of the crew. The areas of the boat we visited were:

- Where boatswain's mates controlled two 30-ton anchors.
- Media department: This is like a FedEx Kinkos®, complete with graphic design services, copiers, computers, photography lab, passport services, and stations for military personnel to email and comminicate with family.
- Combat system department: sophisticated radar, GPS-satellite images, and weapons systems controls.
- Maintenance department: The F-18 jet engines are taken apart, repaired, reassembled and tested here. The crew was understandably proud when they told us how quickly they were able to perform this task.
- Chapel and library: Command Chaplain Cmdr. Cameron Fish manages both religious services and the ship's library, which has loaned mementos from Texas A&M in College Station (my alma mater), George Bush Library. George H.W.'s daughter, Dorothy "Doro" Bush, as the ship's sponsor, helped design these areas.

Break with Rear Admiral

During a tour break, we met visiting Rear Adm. Gregory Nosal, who arrived via helicopter. The rear admiral had become commander of the Carrier Strike Group Two (CSG-2) (one of 11) in January 2012. The carrier strike group usually encompasses one aircraft carrier, eight carrier air wing groups, a guided missile cruiser, destroyer squadron, and attack submarines. CSG-2 deploys to either the U.S. Sixth Fleet in the Mediterranean or the U.S. Fifth Fleet in the Indian Ocean and Persian Gulf. We each received an embossed coin with the rear admiral's name and a picture of the ship. The tradition is to always carry these with you; and if you meet the rear admiral again without the coin, you buy the drinks.

Evening Festivities

Capt. Luther hosted a white tablecloth dinner for us that night. I sat between the ship's attorney and an oral maxillofacial surgeon. After dinner were nighttime take-offs and landings by Navy aviators still working on their carrier landing credential. We then met Command Master Chief David Colton, who is the most senior enlisted sailor

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

F-18 Super Hornet, with tail hook down, comes in for a landing.

Photo: Courtesy of Dr. David Dunn

Standing a few feet away from the wings of these amazing jets, the power/force, heat, and steam I felt was indescribable.

and is liaison between the commissioned officers and the enlisted sailors; he reports directly to the commanding officer. He told us fascinating stories about the recent seven-month deployment overseas. We received his coin, as well. After that, we retired to our DV quarters: two per room with carpet, bunk beds, lockers, and a flat panel television. Our room was called the CIA director's room, named after George Bush's position during Gerald Ford's presidency. After winding down to reconvene early, we went to sleep. Our room was directly under the catapult and for hours we felt and heard teeth-jarring launches, so finally I put in earplugs. Fortunately, the launches stopped just before midnight.

Jan. 27, 2012 —Last Day

A quick shower and a large breakfast started off our second tour day, with many more ladder steps to negotiate. We were shown the ship's food storage area and cavernous refrigerated area with food crates. We saw where three meals a day are prepared for up to 5,000 people.

Medically Well-equipped

Senior Medical Officer Dr. Kimberly Toone led us on a tour of the medical facilities. She was a ball of fire, treating us to many hilarious quips. A graduate of the University of Florida College of Medicine, she had served as medical support on five space shuttle launches. We saw the lab, the X-ray department, operating rooms, and rehab area. During their last seven-month deployment, they had performed appendectomies, cholecystectomies, and a small bowel resection. Impressively she had taught all the sailors how to treat a sucking chest wound, reiterating that the carrier was an immensely dangerous work environment. With protocols and endless training, however, it seemed very safe. We saw firemen performing timed exercises in which they outfitted themselves into fire gear, complete with oxygen tanks. We witnessed Dr. Toone lead a ship-wide disaster drill.

Well-stocked Store

One of our last stops was the well-stocked store where we bought souvenirs. I also tried replacing my lost readers, but they didn't carry those kinds of eyeglasses because the average enlisted sailor and officer is twice as young as I am.

Choppy Seas Cause Delays

Scattered storms developed, leading to much rougher seas with five- to seven-foot swells. Looking on the bright side, this provided great training for the new pilots. The CODs could not leave Norfolk because of inclement weather, and for awhile we were hoping for an extra night on board. After a couple of hours delay, however, the C2 Greyhound was able to launch and land. We loaded onto the plane and the steam catapult launched us from 0 to 128 mph in three seconds. After our return to Norfolk Navy Base, we returned the protective equipment, said our goodbyes, and loaded up for a ride to the airport and our return to Nashville.

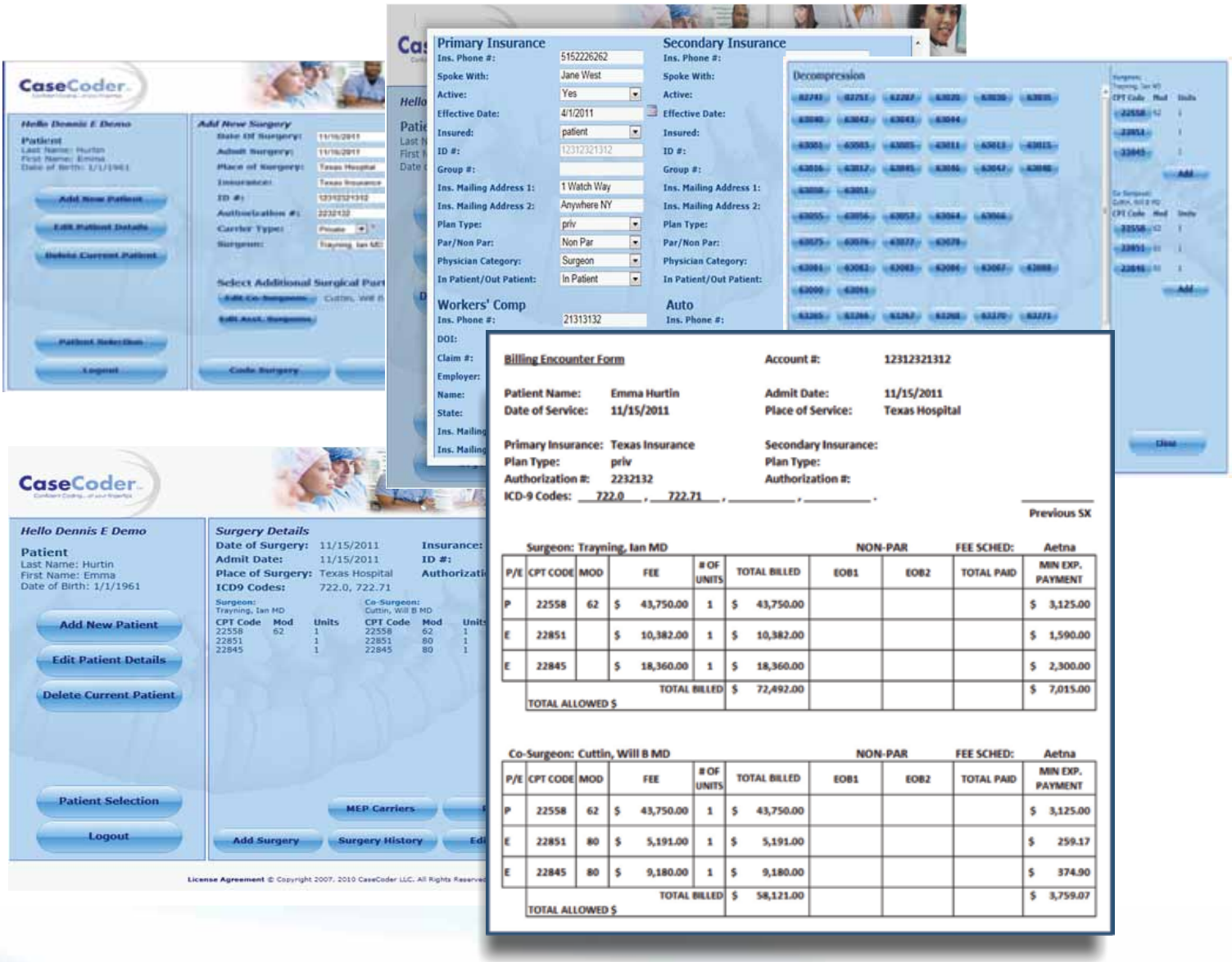
Filled with American Pride

My colleagues and I talked non-stop about our experience on the ride to the airport. Afterwards, we shared photos and got together to watch a video of our experience, again talking non-stop to family, friends, and coworkers. It was amazing to have an up-close view of our Navy with its marvelous technology. As I watched everyone perform their jobs with expertise, precision, and confidence and with a very positive attitude, I was struck with a tremendous sense of pride for these brave men and women who choose to serve and protect America. This 30-hour unforgettable adventure was the invigorating experience of a lifetime.

More than ever, I am proud to be an American.

David Dunn, MD, is vice president of ZHealth. He oversees physician coding and participates as an instructor for ZHealth educational programs and is a contributor to Dr. Z's *Medical Coding Series*. A graduate of Texas A&M University, he completed his M.D. at the University of Texas, his surgical residency at Scott & White Hospital, and his vascular surgery fellowship at Baylor College of Medicine. A diplomat of the American Board of Surgery, Dr. Dunn is also certified in Vascular Surgery. He is a fellow of the American College of Surgeons, a member of the Southern Association for Vascular Surgery, and president-elect of AAPC's National Advisory Board (NAB).

CaseCoderExtreme™



Spine Claims Auditing Technology to Revamp Your Revenue Cycle

www.casecoder.com
888-337-8220 option 5

CaseCoder™
Confident Coding... at your fingertips

By Michelle A. Dick

Inside the Military Health System and Coding

See how health care, EHRs, documentation, ICD-9-CM, ICD-10, and CPT® work for the military population.

Coding Edge asked military health experts to provide insight into the military health system (MHS) and coding. Here's what they had to say:

How does the MHS work?

MHS is federally managed medicine for active duty members and their families. According to U.S. Air Force **Lt. Col. (Retired) Jeanne Yoder, CPC, CPC-I, RHIA, CCS-P**, military personnel earn their health care by being in the military.

The MHS is composed of two parts:

- Department of Defense (DoD) – direct care component, which are the military hospitals and clinics
- TRICARE® – the purchased-care component, which is formerly Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

Yoder said, "Where you have large populations of beneficiaries, there tends to be direct care. An example is a hospital on an Army or a Navy base. Air Force bases usually have smaller beneficiary populations, so they tend to have more base clinics."

When care is not available in a direct care facility, beneficiaries receive care in the civilian health care system, with payment being made through TRICARE®, according to Yoder.

What ICD-9-CM codes are used frequently on Navy ships?

Lt. Cmdr. Jori S. Brajer, deputy director for Health Care Operations and the interim department head, Health Information Management, U.S. Navy Bureau of Medicine and Surgery, said, "The types of codes used frequently on Navy ships are those which would normally be found in a primary care setting. Sailors and embarked Marines are medically screened prior to a shipboard or operational assignment. These sailors and Marines are termed worldwide deployable and exhibit no medical issues which cannot be handled on board a sea going vessel."

Yoder said, "Ships usually have a healthy population of individuals 18-45 years of age. This population has the same health issues as most other healthy 18-45 year olds, except for the deliveries." She added, "Common diagnoses are viral and respiratory conditions with a sprinkling of cuts, contusions, sprains, and strains."

How is documentation handled?

"Documentation in the medical record for sailors and Marines on board ships is generally the same as it would be in our fixed medical treatment facilities and the civilian sector, said Brajer. "Currently, the documentation is generally made in the paper medical record, but the Navy is transitioning to an electronic encounter documentation system on board ships."

As for land-based direct care facilities, Yoder said, "Documentation is in the form of an electronic health record (EHR) program called Armed Forces Health Longitudinal Technology Application (AHLTA). Most coding is template based, done by the health care provider.

Walk us through the process from when a diagnosis is made (or procedure is preformed) and documented to when a claim is billed.

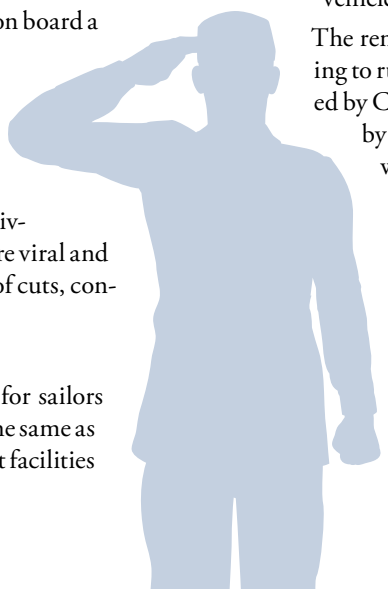
Yoder said, "Once a diagnosis is made, the provider codes the encounter in AHLTA. There are nightly data feeds to the MHS central repositories with all data needed to generate a bill. This data also resides on the local servers. Approximately 5 percent of care is billed. There are three major billing programs:

- *Third Party Collections* generates bills for patients who have other health insurance. In general, these are the retirees and their family members who have medical insurance through their employers.
- *Medical Services Account* billing is for interagency billing, such as when the DoD has an agreement with the Veterans Healthcare Administration or a Department of Defense Dependents Schools (DoDDS) teacher receives care.
- *Medical Affirmative Claims* recovers the cost of medical treatment for DoD beneficiaries who are injured at the fault of a third party, such as when someone with automobile insurance injures a beneficiary in a motor vehicle accident.

The remaining 95 percent of care is not billed. The funding to run the facilities and pay the employees is appropriated by Congress in the DoD budget. The funds are received by the TRICARE® Management Activity (TMA) who works with the TriServices (There are only Army, Navy, and Air Force facilities; most Marine care is provided by the Navy.) to equitably distribute the funds."

Is procedural coding the same?

According to Navy Neurosurgeon **Lt. Cmdr. Stacey Wolfe, MD**, at Tripler Army Medical Center, the Navy and all of the military use the same CPT® codes for coding as civilian health systems.



The Navy will be prepared to implement ICD-10 by the proposed Oct. 14, 2014 deadline.

How is the military preparing for ICD-10?

Brajer said, "All of the services are working in concert with the TMA to prepare for ICD-10 in accordance with the federal mandate from the U.S. Department of Health & Human Services." The Navy will be prepared to implement ICD-10 by the proposed Oct. 14, 2014 deadline.

"Navy Medicine has established a governance and leadership structure for decision-making, issue resolving, and determining the resources necessary as the Navy medicine implements ICD-10," according to Brajer. "A project management office was deployed for ICD-10 Program Management Office (PMO), which is assessing the functional, business, and technology areas. The ICD-10 PMO drives and provides a planned structured approach to integrate, coordinate, and support ICD-10 evaluation and implementation progress, staffing and resources." Brajer said they are "in the assessment phase, which is to identify the impact to people, processes, procedures, and technology. The ICD-10 assessment is to be followed by implementation and sustainment phases."

"The MHS has been preparing for ICD-10 since 2004," Yoder said. "Years ago, all computer systems using ICD-9-CM codes were identified. Examples include the blood system, aeromedical evacuation system, theatre medical systems (e.g., those used in deployed situations such as Iraq), and facility-based systems (e.g., clinic, inpatient, laboratory, radiology, immunizations, disability, pharmacy)." MHS has been reviewing all internal code edits and updating systems. "For instance," Yoder said, "the major changes in trauma, external causes of morbidity, physical therapy, and obstetrics have all driven significant work. There are groups of individuals who have reviewed all of the policy regulations (e.g., *TRICARE manuals*), directives, instructions, and forms, which have all been updated for ICD-10-CM and ICD-10-PCS coding. Another group identified those who would need training. The planning is ongoing."

Michelle A. Dick is executive editor at AAPC.

A&P Quiz

By Rhonda Buckholtz, CPC, CPMA, CPC-I

Think You Know A&P? Let's See …

Asthma is a common disease affecting approximately 5 percent of the population. Each year, approximately 470,000 hospital admissions are due to asthma. Asthma is a chronic inflammatory disorder of the airway and is caused by inflammation in the airways. When an asthma attack occurs, the muscles surrounding the airways become tight and the lining of the air passages swells. This reduces the amount of air that can pass through.

In sensitive people, asthma symptoms can be triggered by breathing in allergy-causing substances (called allergens or triggers). Most people with asthma have attacks separated by symptom-free periods. Some people have long-term shortness of breath with episodes of increased shortness of breath. Either wheezing or a cough may be the main symptom. Asthma attacks can last for minutes to days, and can become dangerous if airflow is severely restricted. Symptoms include:

- Cough with or without sputum (phlegm) production
- Pulling in of the skin between the ribs when breathing
- Shortness of breath that gets worse with exercise or activity
- Wheezing, which:
  - Comes in episodes with symptom-free periods in between
  - May be worse at night or in early morning
  - May go away on its own
  - Gets better when using drugs that open the airways
  - Gets worse when breathing in cold air
  - Gets worse with exercise
  - Gets worse with heartburn
  - Usually begins suddenly

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

Common respiratory irritants include all, but which of the following?

A. Fumes from burning wood or gas
B. Pollution
C. Tobacco smoke
D. Dust mites

The answer to this question is located somewhere in this issue!

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

By Marty Kotlar, DC, CHCC, CBCS

Document Chiropractic Group and Individual Therapy Differences

Increase your chances of reimbursement for group and specific therapeutic procedures.

Last month, we discussed coding and billing for therapeutic procedures and modalities in chiropractic practice, concentrating on services provided to individual patients ("Add Therapeutic Procedures and Modalities to a Chiropractic Practice," pages 22-25). This month, we'll explore proper billing and coding for group therapy, as well as additional individual therapy not covered last month.

Group vs. Individual Therapy Billing

photo by Stockphoto©Christopher Pattberg

Takeaways:

- Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact. Individual therapy requires direct, one-on-one patient contact for approximately 15 minutes with the provider to effect change.
- Billing for both individual (one-on-one) and group services provided to the same patient on the same day is allowed, if the rules for one-on-one and group therapy are both met.
- Several things should be done to help you, the payer, and the patient manage an unlisted or uncovered modality.

Group therapy consists of simultaneous treatment for two or more patients who may (or may not) be doing the same activities. Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact. If a doctor of chiropractic (DC) is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of group therapy using CPT® 97150 *Therapeutic procedure(s), group (2 or more individuals).*

Documentation to support 97150 must identify the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, the number of persons in the group, and the treatment goal in the individualized plan. The specific therapeutic procedure should not be reported in addition to this group therapy code.

For example: In a 25-minute period, a DC works with two patients, A and B. The DC moves back and forth between the two patients, spending a minute or two at a time with each, providing occasional assistance and modifications to patient A's exercise program and offering verbal cues for patient B's balance activities.

The proper coding for both patients is 97150. Documentation should identify the specific treatment technique(s) used in the group, how the treatment technique will restore function, the frequency and duration of the particular group setting, the number of persons in the group, and the treatment goal in the individualized plan.

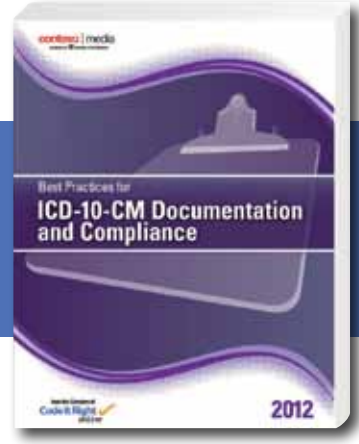
Consider this one-on-one therapy **example**: A DC works with three patients, A, B, and C, providing and supervising therapeutic exercises to each patient with direct one-on-one contact in the following

2012 Best Practices for ICD-10-CM Documentation and Compliance

Understanding the new documentation requirements for ICD-10-CM is vital to a successful transition to ICD-10. ICD-10-CM requires more detailed documentation for assignment of the most specific diagnosis code(s).

The **2012 Best Practices for ICD-10-CM Documentation and Compliance** addresses the documentation analysis phase of ICD-10-CM coding and provides all the tools required for an effective documentation analysis and a corrective action plan including:

- **Comprehensive review of each ICD-9-CM chapter and the corresponding ICD-10-CM chapter** or chapters with identification of diagnoses/conditions requiring additional documentation and discussion of the relevant coding guidelines and coding notes
- **An ICD-9-CM to ICD-10-CM comparison of code categories and subcategories** requiring more specific documentation
- **A table with ICD-9-CM codes and the applicable ICD-10-CM** codes for the same condition
- **Checklists to identify the new documentation elements** for categories, subcategories and/or codes in ICD-10-CM
- **Scenarios showing required documentation in ICD-9-CM and ICD-10-CM** with the additional documentation elements in ICD-10-CM highlighted
- **Codes (ICD-9-CM and ICD-10-CM) and explanations including applicable guidelines** for each scenario
- **End of chapter quizzes** including coding practice of conditions discussed in the chapter
- **Specialty-specific checklists** for documentation review of current records to help identify documentation deficiencies
- **And more!**



NEW!

Regular Price: $159.95 **Your Price: $127.96**

Order your copy at www.codingbooks.com/documentation.
Be sure to enter promo code **AAPCDOC** to receive your discount.

contexo | media 4 Choke Cherry Road, 2nd Floor | Rockville, MD 20850 | www.codingbooks.com | Tel: 1-800-334-5724

The group therapy session must be clearly distinct or independent from other services.

sequence: Patient A receives three minutes, patient B receives three minutes, and patient C receives three minutes. After this initial nine-minute period, the DC returns to work with patient A for five more minutes (eight minutes total), then patient B for 12 more minutes (15 minutes total), and finally patient C for 15 additional minutes (18 minutes total). When the patients are not receiving direct one-on-one contact with the DC, they are each exercising independently.

Each patient can be billed one unit of therapeutic exercise, CPT® 97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.*

This scenario is different from group therapy because individual therapy requires direct, one-on-one patient contact for approximately 15 minutes with the provider to effect change by applying clinical skills and/or services attempting to improve function.

Same-day Billing

Billing for both individual (one-on-one) and group services provided to the same patient on the same day is allowed, if the rules for one-on-one and group therapy are both met.

For example: A patient is in a group setting with several other patients performing exercise therapy. The patient is then seen by the DC, who provides direct one-on-one contact for approximately 15 minutes, applying clinical skills and/or services to improve function.

The group therapy session must be clearly distinct or independent from other services. CPT® 97150 and the one-on-one codes (e.g., 97110, 97112 *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities*) are subject to National Correct Coding Initiative (NCCI) edits, which require group therapy and one-on-one therapy to occur in different sessions, timeframes, or separate encounters distinct or independent from each other when billed on the same day. Use modifier 59 *Distinct procedural service* when billing both group therapy and individual therapy CPT® codes to distinguish the two coded services as different sessions or separate encounters on the same day.

Reporting Therapeutic Activities and Self-care Training

Therapeutic activities (97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes*) use functional activities (e.g., bending, lifting, carrying, reaching, catching, and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the professional skills of a provider and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

An example of 97530 might be to increase flexibility of the quadratus lumborum muscles while activating and stretching the hamstring muscles to improve the patient's capacity for walking and standing.

Self-care/home management training (97535 *Self-care/home man-*

How to Report Time-based Therapy Codes

Remember the Medicare guidelines for reporting time-based therapy codes reviewed last month. Namely:

1 unit = 8-22 minutes

2 units = 23-37 minutes

3 units = 38-52 minutes

4 units = 53-67 minutes

If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, bill at least one unit. If the service is performed for at least 30 minutes, bill at least two units, etc.

When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service, as noted in the chart above, determines the number of timed units billed.

Per Medicare rules, when a 15-minute timed service is performed for seven minutes or less on the same day as another 15-minute timed service also performed for seven minutes or less, and the total time of the two is eight minutes or greater, bill one unit for the service performed for the most minutes. Apply the same logic when three or more different services are provided for seven minutes or less.

The time of each specific modality and therapeutic procedure provided to the patient should be documented in the subjective, objective, assessment, and plan (SOAP) notes.

photo by iStockphoto©kali9

agement training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes) involves the use of ADL and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment, with direct one-on-one contact by the provider. The patient must have the capacity to learn from instructions. The documentation must relate the training to the patient's expected functional goals, and the procedure must be part of an active treatment plan directed at a specific goal.

The overall goal should be to get the patient to return to the highest level of function realistically attainable and within the context of the presenting problem. The plan of treatment should address specific therapeutic goals for which modalities and procedures are outlined in terms of type, frequency, and duration. There must be an expectation the condition will improve significantly in a reasonable and generally predictable time period, based on the assessment of the patient's rehabilitation potential.

Note: Therapeutic procedures and modalities are not covered by insurance when the documentation indicates the patient has attained the therapy goals or has reached the point where no further significant practical improvement can be expected.

Source: Medicare Benefits Policy Manual, section 220 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance."

Documenting for Success with Unlisted Modalities

Getting paid for unlisted procedures can be complicated; however, there are several things you can do to increase your chances of reimbursement.

To begin with, call the carrier and ask if the procedure you are about to perform is covered. If it is a non-covered service, make sure the patient is made aware of this. Give the name and telephone number of the person you spoke with at the insurance company to the patient, so he or she can ask the carrier for their policy on unlisted procedures and non-covered services.

Even if the carrier does not pay for the unlisted procedure, I recommend billing the carrier. This will help the carrier see that you are providing the service, and the explanation of benefits (EOB) will hopefully show a "patient responsibility" remark code. Sometimes patients want their carriers billed for unlisted and non-covered services so they know for sure they paid you properly. The patient responsibility EOB helps patients become educated on how their carrier processes claims and makes it easier for you to get paid directly.

Often the carrier will deny the unlisted procedure due to "lack of medical necessity." If this is the case, get the carrier to define "medical necessity." Request the definition by fax or email and review it. You may be able to send in a pre-authorization letter in the future. Also, ensure the carrier understands the anticipated cost of the care with and without the unlisted procedure. Insurance carriers are always looking to save money. You should tell them how much money you anticipate saving them by minimizing the risk of future, more expensive procedures.

If you have clinical trials and research conducted by recognized bodies of physicians for the unlisted procedure, make sure you include that information in your pre-authorization letter, as well. Describe the condition of the patient, how much they're suffering, and the impact of the pain on the patient's life. Include a lay-term description of the procedure in your letter so anybody who reads it can understand. Try to relate the procedure performed to an existing CPT® code as support for reimbursement. Explain how your procedure differs to show why you didn't choose an existing code.

CPT® 97039 *Unlisted modality (specify type and time if constant attendance)* is a very common unlisted procedure code. Some of the more common procedures linked to 97039 are low-level laser therapy, mechanical massage, and dry hydrotherapy beds. Depending on the service you are providing, 97039 may require direct one-on-one contact for treatment and may be categorized as a constant attendance modality. If you are in-network, contact the carrier to find out their position on 97039 and check the fee schedule: it may be a covered service. Always adhere to the American Medical Association (AMA) official coding guidelines unless your contract with a carrier stipulates otherwise.

Marty Kotlar, DC, CHCC, CBCS, is the president of Target Coding (www.TargetCoding.com). He has been helping chiropractors with reimbursement issues using proper and compliant CPT® coding for over 10 years. Dr. Kotlar can be reached at drkotlar@targetcoding.com.

By Meera Mohanakrishnan, MSc, CPC, CPC-H, CPC-P

2012 Coding Update: Needle EMG with NCV

Medicine code changes require physicians and coders to pay even more attention to detail.

photo by iStockphoto/©BankPhotos

CPT® 2012 updates reporting for electrodiagnostic testing with the addition of three codes to describe electromyography (EMG) services performed with a nerve conduction study (NCS).

+95885 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)

+95886 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, 5 or more muscles studied, innervated by 3 or more nerves or 4 or more spinal levels (List separately in addition to code for primary procedure)

+95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

An EMG measures the electrical activity of muscles at rest and during contraction. An NCS measures how well, and how fast, the nerves can send electrical signals. Because these studies provide complimentary information, they are often carried out jointly (for instance, to diagnose 354.0 *Carpel tunnel syndrome*).

Prior to 2012, EMG was reported separately using 95860-95864 (depending on the number of limbs tested) when performed with an NCS. With the introduction of CPT® 2012, when needle EMG is provided during the same session as a NCS, report the NCS as the primary procedure and turn to +95885-+95887 (depending on location and extent) to describe the EMG.

Code Application Is in the Details

To help your physicians performing EMG with a NCS, be aware of documentation requirements you'll need to assign codes correctly.

- **95885** describes limited testing of four or fewer muscles when nerve conduction studies (95900-95904) are performed on the same day. Report one unit for each extremity tested. The code can also be used for muscles on the thorax or abdomen (unilateral or bilateral). The physician's report should identify the muscles tested.
- **95886** requires evaluation of extremity muscles innervated by three nerves (for example, radial, ulnar, median, tibial, peroneal, femoral, not sub-branches) or four spinal levels, with a minimum of five muscles studied per limb. One unit includes all muscles tested in a particular extremity, with or without related paraspinal muscles; up to four units of

Whenever reporting EMG or NCS, you must be aware of minimum requirements that many payers impose ...

service (one per limb) may be reported per patient for a given examination. The physician's report should identify the muscles tested.

- **95887** describes EMG testing at the same time as the NCS for non-extremity muscles. Only one unit may be reported per day. The physician's report should identify the muscles tested.

Add-on codes 95885-95887 must accompany an appropriate NCS primary procedure code (95900-95904). Codes 95885 and 95886 may be reported together up to a combined total of four units per patient when all four extremities are tested. Codes 95885-95887 should not be reported with other EMG procedures 95860-95864 or 95870 *Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters*; or motor/sensory NCS by preconfigured array, 95905 *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report*.

Coding Example: A physician performs three motor nerve conduction velocity (NCV) without F wave tests, two sensory NCV tests, one limb EMG testing six muscles, and a separate limb EMG testing three muscles. Correct CPT® coding is:

Motor NCV w/o F wave - 95900 x 3 units

Sensory NCV - 95904 x 2 units

EMG, complete - 95886 x 1 unit

EMG, limited - 95885 x 1 unit

EMG Alone Calls for Dedicated Codes

Standalone EMG codes (95860-95864) may be reported when only the EMG study is performed. They cannot be used if the EMG study is performed on the same day as the NCS.

For example, a physician performed a two-limb EMG without NCV on the same day. Both limbs included testing six to seven muscles. In this case, you would report a two-limb EMG with 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (no NCS performed).

You may report 95870 *Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters* for muscles other than the paraspinals associated with the extremities that were tested. Do not report 95870 when the paraspinal muscles corresponding to an extremity were tested and extremity EMG codes 95860-95864 are also being billed.

Watch Out for Billing Requirements and Limitations

Whenever reporting EMG or an NCS, be aware of minimum requirements many payers impose, such as requirements shared by several Medicare contractors:

- The number of limbs or areas tested should be the minimum needed to evaluate the patient's condition.
- It is expected that the NCV and EMG reports will contain data from the study as well as the interpretation and diagnosis.
- Repeat testing should be infrequent; limitation of testing services will be determined on the basis of individual medical necessity. An excessive number of services may result in a delay in processing, a denial of the claim, or a request for a refund.
- Documentation addressing the need to evaluate the patient must be maintained by the practitioner and made available to Medicare upon request.
- Documentation stating the indications and circumstances requiring individual nerve conduction studies (without EMG) must be maintained by the provider and made available upon request.

Note also that Medicare places frequency limitations on EMG and NCS procedures, and will reimburse only for the following numbers of tests per year per patient:

- 95900 – eight per year
- 95903 – eight per year
- 95904 – 10 per year
- 95905 – one per limb per year, no more than four per year
- 95934 – two per year
- 95936 – two per year

Per Medicare, reimbursement for additional tests (beyond the number allowed above) will require medical record review.

Meera Mohanakrishnan, MSc, CPC, CPC-H, CPC-P, is manager of operations training at OptumInsight/UnitedHealth Group. You can reach her at meera_mohanakrishnan@uhc.com.

Certified Professional Practice Manager

The CPPM™ credential is a logical next step for those with strong physician office experience who are ready to advance their careers in practice management. The requirements of managing the revenue cycle, compliance regulations, and general business processes make practice management a challenging yet rewarding profession.

CPPM™

Training & Exam Registration Now Available

AAPC

Learn more at:
www.aapc.com/cppm

By Rena Hall, CPC

Taking the CPC® Exam?

Here Are a Dozen Tips to Help

Testing advice from someone who has been there, done that, and worn the T-shirt.

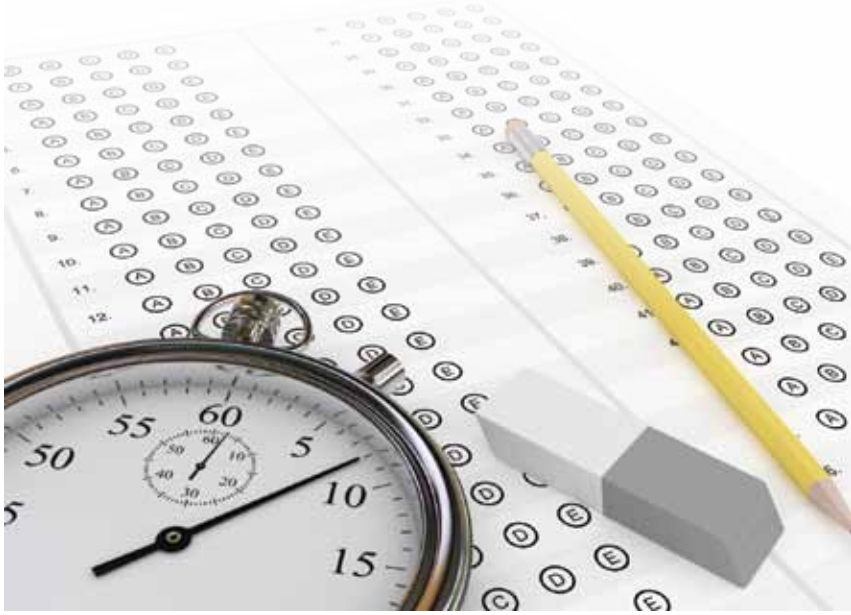


photo by iStockphoto/Bodo Dürigel

Here are what I like to call my "dirty dozen" tips for passing the Certified Professional Coder (CPC®) examination:

1. **Practice finding codes quickly.** Looking up codes is a "time bandit" during the exam. To help make you faster, write down several ICD-9-CM, CPT®, and HCPCS Level II codes on pieces of paper and placing the pieces in the corresponding bag (one bag for each code set). Draw one out and time how long it takes you to find the code. This can be done almost anywhere. For example, the next time you go to an appointment, take one baggy and its corresponding book, and practice while waiting.
2. **Become familiar with CPT® section guidelines,** as well as the symbols next to many codes. Make notes in your books to help you locate specific codes.
3. **Don't over-study at any given time.** You will tend to forget more than you learn.
4. **Do not cram the night before.** Pace your study time so you have the night before the test to clear your mind and get some rest. Do something relaxing that night. Go to bed early and eat a good breakfast on test day.
5. **Take mental breaks** every hour during the test. Just a few seconds of deep breathing will help you stay alert to finish the test. Stretch your arms above your head to loosen your muscles.
6. **Read each question twice** before answering. Do not skim the question. Reading it twice may provide you with a key word you missed the first time. Underline key words.
7. **Don't spend too much time on one question.** Spending too much time and energy on one question may not leave enough time to answer easier ones. Mark the hard question on the answer grid with a small dot, so you know to come back to it. For electronic tests, if you're allowed a piece of paper, write down the question number. (Remember: Erase anything on the paper answer grid except your answer!)
8. **Take allotted breaks.** Just standing up and walking around can relieve stress.
9. **Drink water or juice.** Caffeine and energy drinks may boost your energy for a short time, but you will feel even more tired when the effect wears off, which might be while you're taking the test.
10. **Take a protein-packed snack.** Nuts are filling without making you feel uncomfortable, and there's no fear of crashing from a sugar high. Open the bags before the test starts, however, to prevent making noise during the exam.
11. **Give yourself room to work.** Organize your resources to make them easily accessible.
12. **Consider taking earplugs** to the test if you are easily distracted by noises.

Rena Hall, CPC, began her career in the medical field as a medical assistant in 1982. She became a certified coder in January 2001 and has been an active member of the AAPC Kansas City, Mo. Local Chapter since her certification. Ms. Hall has worked for the same neurosurgery group for almost 26 years.

By Ronda Tews, CPC, CHC, CCS-P

From Paper to EHR, "Detailed" Means "Detailed"

EHRs must follow the same documentation requirements as paper records.

Contrary to any rumors you may have heard, the electronic health record (EHR) must follow the same documentation requirements as its predecessor, the paper chart. If a detailed history is required to bill 99214 or 99203 in the paper record, it is *still* required to report 99214 or 99203 when documenting with an EHR.

It is not true that if the information is located "somewhere" in the EHR it may be counted toward the documentation requirements for any and all dates of service. The provider must reference within his or her note for *that date of service* if he or she has reviewed any information within the EHR to get credit for the information.

For example, if the provider does not document any past medical, family, or social history (PFSH) within his or her note, how would an outside auditor know there is PFSH in the EHR; and how would the auditor know the provider reviewed the information on that date of service? The auditor wouldn't know, and wouldn't likely go looking for the information or assume the provider reviewed it.

Here's how Medicare carrier Wisconsin Physician Services (WPS) addresses this topic in a Q&A (see www.wpsmedicare.com/j5macpartb/resources/provider_types/2009_0526_emqahistory.shtml):

"**Q 16.** This question pertains to an Electronic Medical Record (EMR.) We have always been taught that the progress note 'stands alone.' When we are auditing physician's notes to determine if they are billing the appropriate level of service, what parts of the EMR can be used toward their levels without requiring them to reference it? We are referring specially to Growth charts, Past, Family, & Social History, Medication Listings, Allergies, etc."

Takeaways:

- Electronic health records (EHRs) must meet the same document requirements as a paper chart.
- The provider must note in the EHR that information was reviewed on the day of service, rather than somewhere else in the system.
- Payers want complete, but not extraneous, documentation from physicians.

"**A 16.** If the physician were not referencing previous material in the EMR, then the information would not be used in choosing the level of E/M service."

TrailBlazer addresses the same topic in a document titled "Part B Tips for Preventing Most Common E/M Service Coding Errors:"

"All history obtained and recorded by triage and other hospital nursing staff must be specifically repeated by the physician and either re-recorded or annotated with specific comments, additions, and/or corrections and notation of the elements of work personally performed by the physician."

The old adage still applies to the EHR: If it isn't documented, it wasn't done.

EHRs Bring Unique Benefits, Challenges

Many providers were told the EHR was going to make their lives simpler by cutting down on documentation time. This is somewhat true because the EHR allows providers to have test results at their fingertips, and instant access to patients' previous visits by all providers tied to that specific EHR. Documentation of the visit has proven to be a bit more tedious for most providers, however.

Templates are beneficial, but create their own problems. For instance, a provider may have a template created including a review of systems (ROS) and examination. The provider pulls this template into every note to save documentation time, but in the business of her day may not make appropriate additions and/or deletions to the template based on the patient's presenting problem(s). As a result, the documentation begins to look the same for each patient and may contain conflicting information. For example, the note may say, "The patient presents for runny nose, cough, and sneezing," yet the ROS template may say "ENT: Negative for congestion, sneezing, postnasal drip, ear pain, or sore throat."

As a result, the Office of Inspector General (OIG) has warned:

"Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. … Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. … Identification of

The old adage still applies to the EHR—if it's not documented, it wasn't done.

this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made."

This does not mean that providers cannot use templates, but appropriate changes need to be made to the template based on the patient being seen and the treatment being performed. The provider's comprehensive, 10-system ROS probably is not necessary for a patient who presents with a sore throat, but may very well be needed for a patient presenting with chest pain.

Documentation Volume Doesn't Determine Coding, Necessity Does

As our Medicare carriers begin to see the beefed-up documentation EHRs allow, they may place restrictions or limitations on requirements to bill the higher-level evaluation and management (E/M) codes.

For instance, TrailBlazer (Medicare carrier for Texas, Oklahoma, Colorado, and New Mexico) has stated in "Documenting Components of an Established Office E/M Service," "**Do not record unnecessary information solely to meet requirements of a higher-level service** when the nature of the visit dictates a lower-level service to be medically appropriate" [emphasis in original]. This mirrors national Medicare policy, which asserts, "It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed," (CMS transmittal 178, change request (CR) 2321, May 14, 2004).

Watch Out for Lists

Diagnosis coding also faces new challenges as a result of EHR implementation. Some EHRs have the capability of bringing in the patient's established problem list to each visit. This is fine, as long as the provider is treating each one of those established problems on that date of service and documentation supports all diagnoses billed for that date of service.

For example, a patient is seen for a minor, acute problem such as sinus infection, yet the only diagnoses attached to the claim for that date of service are hypertension and osteoarthritis, which were the diagnoses on the patient's problem list. In this case, the documentation does not support the diagnoses for that date of service. The provider must know how to find the appropriate diagnoses in the EHR, as well as how to attach the diagnoses to the visit. If an established problem list populates within the provider's note, he or she will need to disassociate any diagnoses he or she does not treat on that date of service.

As EHR adoption becomes more widespread, I believe we will see Medicare carriers crack down on documentation requirements by putting into place and enforcing more stringent E/M documentation rules. Coders and clinicians will do fine, however, as long as they follow the established rules for documenting services in the pre-EHR era. Providers must document everything they did to be reimbursed appropriately—the EHR did not take away that requirement.

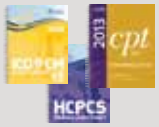
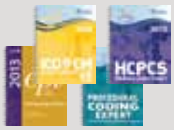
Remember: The purpose of the EHR is to improve patient care; and a detailed history still equals a detailed history.

Ronda Tews, CPC, CHC, CCS-P, is a senior financial analyst in revenue compliance for Mercy in St. Louis. Ms. Tews conducts E/M audits for all Mercy providers in Oklahoma. Her duties have included establishing internal auditing and monitoring; teaching coding classes; providing E/M documentation training to providers; implementing compliance education and training programs; and managing the Report Line. She also provides education to physician assistant students at Missouri State University. Ms. Tews has been in the health care industry for over 20 years, and has served as secretary and president of her local AAPC Chapter.

2013 CODE BOOKS

Lowest Prices Anywhere

Bundles

	***Physician Bundle 3*** **Our Best Value!** ICD-9 1 & 2 • HCPCS • Procedural Coding Expert	~~$304.85~~ **$124.95**
	***Physician Bundle 1*** ICD-9 1 & 2 • CPT® • HCPCS Level II	~~$304.85~~ **$169.95**
	***Hospital Bundle 1*** ICD-9 1-3 • CPT® • HCPCS Level II	~~$308.85~~ **$179.95**
	***Physician Bundle 2*** ICD-9 1 & 2 • HCPCS • CPT® • Procedural Coding Expert	~~$414.80~~ **$209.95**
	***Hospital Bundle 2*** ICD-9 1-3 • HCPCS • CPT® • Procedural Coding Expert	~~$418.80~~ **$219.95**

Individual Books

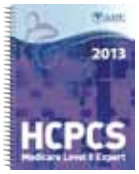
ICD-9-CM Vol. 1-2

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

ICD-9-CM Vol. 1-3

~~$103.95~~ **$64.95**

HCPCS Level II



~~$94.95~~ **$54.95**

Procedural Coding Expert

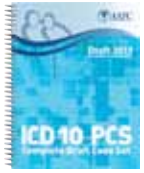
~~$109.95~~ **$64.95**

AMA's CPT® Professional

~~$109.95~~ **$94.95**

ICD-10

ICD-10-PCS



~~$99.95~~ **$79.95**

ICD-10-CM

~~$99.95~~ **$79.95**

AAPC
Credentialing the Business Side of Medicine

Pre-order Today!
www.aapc.com/2013codebooks
1-800-626-CODE (2633)

newly credentialed members

Alesia M Allen, **CPC**
Alyssa Neis, **CPC**
Amanda S Lester, **CPC**
Amber West, **CPC-H**
Amie Champa, **CPC**
Amy E Stevens, **CPC**
Amy Godwin Helms, **CPC**
Amy L Carpenter, **CPC**
Amy Siano, **CPC**
Andrea Devlin, **CPC**
Andrea Fortune, **CPC**
Andrew Wright, **CPC-H**
Aneta Lukasiewicz, **CPC**, CPC-H
Angel Xavier, **CPC**
Angela Briggs, **CPC-H**
Angela Gail Smith, **CPC**
Angela Jackson, **CPC-H**
Angela Mercer, **CPC**
Angelica L Abrahams, **CPC-H**
Angelina Green, **CPC**
Angelo J Natoli, **CPC**
Anita Fredieu, **CPC**
Anna Evans, **CPC**
Anne Crawley, **CPC**
Anne Marie Busa, **CPC**
Annette W Hardy, **CPC**
Antoinette Stoll, **CPC**
Audrey L Deckard-James, **CPC**, CPC-H
Audrey McFarland, **CPC-H**
Aurthy Panneerselvam, **CPC**
Barb La Motte, **CPC**
Barbara McDowell, **CPC**
Beatrice K Franklin, **CPC-H**
Beth A Peront, **CPC**
Beth Ann Conant, **CPC**
Beth Voce, **CPC**
Bethany Daniel, **CPC**
Betty Sargent, **CPC**
Beverly R Jackson, **CPC**
Bobiann McMinn, **CPC**
Brady Hornback, **CPC**
Brittany Lee Lorenz, **CPC**
Carla Lander, **CPC**
Carla Marie Thibodeaux, **CPC**
Carol J Ritchey, **CPC-H**
Carolina M Murray, **CPC**
Carolyn Williams, **CPC**
Cat Levitsis, **CPC**
Charlotte Fisher Davis, **CPC**
Cheyanne Roseberry, **CPC-H**
Christina M Root, **CPC**
Christine Marie Wynn, **CPC**
Cindy Birardi, **CPC**
Crystal Kelder, **CPC**
Cynthia Ludack, **CPC**
Cynthia Marie Cuthbertson, **CPC**
Cynthia Wethington, **CPC**
Danielle Hawkins, **CPC**
Dawn Correira, **CPC**
Deanna Marie Love, **CPC**
Deanna Miller, **CPC-H**
Debbie Brooks, **CPC**
Debbie Chicoine, **CPC**
Deborah Anne Oakes, **CPC**
Deborah Koesters, **CPC**
Dee Dee Stilwell, **CPC**
Deepa Selvakumar, **CPC**
Deidra Harris, **CPC**
Denise Holtz, **CPC**
Denise R Zody, **CPC**
Denise Williams, **CPC**
Diana Crider, **CPC**
Diane Crumpton Turner, **CPC**
Diane Rickards, **CPC**
Divya Annamalai, **CPC**
Donna A Bellemore, **CPC**
Doris Vick, **CPC**

Dorothy M Rogers, **CPC**
Doshia M Walker, **CPC**
Elakkiya Karunanidhi, **CPC**
Eldimaury Marrero Cabrera, **CPC**
Eleinys Pupo, **CPC**
Elisha Karsky, **CPC**
Elizabeth Keen, **CPC**
Erica L Rodgers, **CPC-H**
Erica Lindley, **CPC**
Felecia Littleton, **CPC**
Frances Madrid, **CPC**
Gail A Urick, **CPC**
Gail Evans, **CPC-H**
Gail Marie Steeves, **CPC**
Gina Aydelott, **CPC-H**
Ginger Rogers, **CPC**
Grace Powell, **CPC**
Heather Marie Wilder, **CPC**
Heather Ochoa, **CPC**, CPC-P, CPMA
Heather Pinero, **CPC**
Heidi Schoedel, **CPC**
Helen Virginia Bair, **CPC**
Holly Ann Millon Sainte-Claire, **CPC-H**
Jackie Bakken, **CPC-H**
Jacqueline Pichirilo, **CPC**
Jacqueline Reed, **CPC**, CPC-H
Jaime Wills, **CPC**
James W Bailey, **CPC**
Jamie Addler, **CPC-H**
Jamie Mary Gillespie, **CPC**
Jan Hyson, **CPC**
Jane Beth Vaum, **CPC**
Janice Christine Turner, **CPC**
Janis Lynne McArthur, **CPC**, CPC-P
Jayne Probst, **CPC**
Jennifer D Poston, **CPC**
Jennifer Elkins, **CPC**
Jennifer Lynn Sayegh, **CPC**
Jennifer Lynne Claus, **CPC**
Jennifer Renee Stanley, **CPC-H**
Jeri Ann Stanfill, **CPC**
Jessi Schacher, **CPC-H**
Jessica Keeler, **CPC**
Jessica L Grove, **CPC**
Jim Burnett, **CPC**
Jo Ann Somerville, **CPC**
Joan Arc Anderson, **CPC**
Joanna Jenkins, **CPC**
JoAnne Orzano, **CPC**
Joyce B Griffin, **CPC**
Judith A Schoenfelder, **CPC**
Judy Bekker, **CPC**
Judy Harrison, **CPC-H**
Julia Caruso, **CPC**
Julia Kearns, **CPC**
Julie McDermott, **CPC**
Kalpana Subramaniam, **CPC**
Kandice Horton, **CPC**
Kandy Lea Umdenstock, **CPC**
Karen Boyd, **CPC-H**
Karen Diane Smith, **CPC**
Karen High, **CPC**
Karen Marie Badure, **CPC**
Karen McCarl, **CPC**
Karen S Ehrhart, **CPC**
Kari Moyer, **CPC**
Karina Laiacona, **CPC**
Katherine E Wilson, **CPC**
Kathleen Dorr, **CPC**
Kathleen Riegel, **CPC**
Kathy Ann Pirtle, **CPC**
Kathy Britt, **CPC**
Katie Patzer, **CPC**
Katie S Welch, **CPC**
Kayla M Habiger, **CPC**
Kelley Sledge, **CPC**
Kelly Jenkins, **CPC**

Kelly Lofquist Struble, **CPC**
Khristi Hassenzahl, **CPC**
Kim Bayak, **CPC**
Kim McBride, **CPC**
Kim Young, **CPC-H**
Kimberly Bowen Clark, **CPC**
Kimberly D Smith, **CPC**
Kimberly Diane Pittman, **CPC**
Kimberly Elaine Smith, **CPC**
Kimberly F Shealy, **CPC**
Kimberly Forbes, **CPC**
Kimberly Petro, **CPC**
Konstantinos G Kontogiannis, **CPC**
Krista Kaye Bird, **CPC**
Kristen Leigh Packard, **CPC**
Kristen Worden, **CPC**
Kristina Kavanaugh, **CPC**
Krystal Dorlac, **CPC**
Kumar Devaraj, **CPC**
Kumari Sambandamoorthy, **CPC**
La'Voncye Artoria Deas, **CPC**
Lakeisha Tate, **CPC**
Lakshminarayanan Murugesan, **CPC**
LaShawn Millhouse, **CPC**
Latonya Brown, **CPC**
Laura Lorence, **CPC**
Laura Glynn, **CPC**
Laura Marie Mitchell, **CPC**
Laura Michelle Davis, **CPC**, CPC-P
Laurie Lynn Jelinek, **CPC**
Laury Wood Ballenger, **CPC**
Lawanda Branson, **CPC**
Leanna Lynn Adamo, **CPC**
Lesia D Glenn, **CPC**, CPC-H
Leslie Hawkins, **CPC**
Linka Ayanna Lindo-Fannin, **CPC**
Lisa Carol Love, **CPC**
Lisa Hernandez, **CPC**
Lisa J Tutt, **CPC**
Lisa Lampkin, **CPC**
Lisa Parker, **CPC**
Lisa Walker Whitlow, **CPC**
Lorena Garcia, **CPC**
Loretta Michelle Lopez, **CPC**
Lori Burkhart, **CPC-H**
Lorraine Ann Johnson, **CPC**
Ltanya Jenkins, **CPC**
Maheswari Asirvatham, **CPC**
Maria Lynn Oberbroeckling, **CPC**
Maribel Escalona, **CPC**
Mariol Fernandez, **CPC**
Mary Grace VP Tran, **CPC**
Mary Jo Nebroskie, **CPC**
Mary K Nickles, **CPC**
Mary Kennedy, **CPC**
Megan Rosales, **CPC**
Melinda Ann Shults, **CPC**
Melinda Maher, **CPC**
Melissa Ann McIntosh, **CPC**
Melissa Buckshaw, **CPC**
Melissa Delaney, **CPC**
Melissa G Griffin, **CPC**
Melissa M Schneider, **CPC**
Melissa Nance, **CPC**
Melissa Perkins, **CPC**
Michael Kakes, **CPC**
Michele Marie Kindberg, **CPC**
Michelle Guy, **CPC**
Michelle Lynn Gilmore, **CPC**
Michelle M Sharma, **CPC**, CPC-H
Michelle Meyer, **CPC**
Michelle Starling Creech, **CPC**
Misty Weldon, **CPC**
Nahid M. Mokhashi, **CPC**
Nancy Bonamico, **CPC**
Nancy Cook, **CPC-H**
Nancy R Parent, **CPC**, CPC-H

Nancy T Chasse, **CPC-H**
Nancy Thompson, **CPC**
NandhaKumar Kaliyappan, **CPC**
Naomie Zappala, **CPC**
Natalie Wood, **CPC**
Nathiya Samikkannu, **CPC**
Nicole Garvin, **CPC**
Nicole Copemann, **CPC**
Nicole Johnson, **CPC**
Nicole L Wynn, **CPC**
Nicole Perez, **CPC**
Nikole Ann Payton, **CPC**
Nina L Chute, **CPC**
Nina L Thierer, **CPC**
Pamala Stenson Ray, **CPC**
Pamela Powell, **CPC**
Pamela Duddles, **CPC-H**
Pamela Susan Gavin, **CPC**
Panneer Selvam Gopal, **CPC**
Patricia Allen, **CPC-H**
Patricia Ann Busse, **CPC**
Patricia Ann Ten Broeck, **CPC**
Patricia Lyn Carr, **CPC**
Patti Ann Jackson, **CPC**
Paula M Carson, **CPC**
Penny C Walker, **CPC**
Rachel Schmautz, **CPC**
Raghuraj Sachithanantham, **CPC**
Raja Anandan, **CPC**
Raja Annamalai Subramanian, **CPC**
Rajkumar Srinivasan, **CPC**
Randi Raymond, **CPC**
Rebecca Spencer, **CPC**
Rebecca Woodhams, **CPC**
Rhonda Bettey, **CPC**
Rikki Herron, **CPC-H**
Robin Thomas, **CPC**
Roma Valentine, **CPC**
Rosaleen Marie Durham, **CPC**
Roxanne Betts, **CPC**
Ruth Ann Arnold, **CPC**
Ruth Ussery, **CPC-H**
Ryan Mcmanama, **CPC**
Salli A Walden, **CPC**
Sandra Atkinson, **CPC**
Sandra J Crowley, **CPC**
Sara Lehman, **CPC**
Sara Wekenman, **CPC**
Sarah Emery, **CPC**
Sarah Marie Reed, **CPC**
Scott Bears, **CPC**
Shannon K David, **CPC**, CPC-H
Shantha Rayappa, **CPC**
Sharon McClintock, **CPC-H**
Shashikumar Natarajan, **CPC**
Sheela Ramachandran, **CPC**
Shon L McDaniel, **CPC**
Sindhu Arumugam, **CPC**
Sree Kumari Kumarasen, **CPC**
Stacy Sao, **CPC**
Stephanie Fletcher, **CPC**
Stephanie Reagan Waller, **CPC**
Stephanie Sheppard, **CPC-H**
Stephanie Turner, **CPC**
Stephanie Wilson, **CPC**
Suguna Govindaswamy, **CPC**
Suman Reddy Duvvuru, **CPC**
Susan Christopher, **CPC**
Susan Marie Healy, **CPC**
Susan Walton, **CPC**
Suzette Tagart, **CPC**
Sylvia Catera, **CPC-H**
Tabitha Collins, **CPC**
Taffy Miller, **CPC**
Tamesia M Hill, **CPC**
Tami Sue Roy, **CPC**
Tanya Lyons, **CPC**

Tanya Niemi, **CPC**
Terry Cunningham, **CPC**
Tiffany Peters, **CPC**
Tiffany Shantel Mier, **CPC**
Tina Lloyd Booth, **CPC**
Tina Louise Evans, **CPC**
Tonya Dawn Nickols, **CPC**
Traci Elizabeth Hain, **CPC**
Tracy Watson, **CPC**
Travis Richard Shisler, **CPC**
Ty Treutelaar, **CPC**
Urime Murtishi, **CPC**
Vasanthi Raman Kuppuswamy, **CPC**
Vasiliki Koutsantonis, **CPC**
Vicki Ann Slaughter, **CPC**
Victoria M Perkins, **CPC**
Vidhya Sudhakar, **CPC**
Vijayakumar Ramalingam, **CPC**
Viola C Rice, **CPC**, CPC-H
Wendy Schirard, **CPC**
Wilda Diane Martin, **CPC**
Xuan Campo, **CPC**
Yadira Alcure, **CPC-H**
Yakelin Canejo, **CPC**
Yaritza Napoles, **CPC**
Zarqa Haseeb, **CPC-H**
Zhuljeta Shyti, **CPC**

Apprentices

Aaron Carrillo, **CPC-A**
Aaron Hart, **CPC-A**
Abhishek Rane, **CPC-A**
Abimbola Abidemi Owoyemi, **CPC-A**
Adbhijit H Doke, **CPC-A**
Adelita Lucero, **CPC-A**
Aidanora Osorno Stea, **CPC-A**
Aimee Garabics, **CPC-A**
Aimee Golliver, **CPC-A**
Akshali Kupade, **CPC-A**
Alaina Starr Carroll, **CPC-A**
Alan Pollock, **CPC-A**
Alana Harris, **CPC-A**
Alexander Mabry, **CPC-A**
Alice M Ingogly, **CPC-H-A**
Alicia Marsh, **CPC-A**
Alma Galan-Acevedo, **CPC-A**
Alma Skube, **CPC-A**
Amanda Bybee, **CPC-A**
Amanda Cherry, **CPC-H-A**
Amanda Lescard, **CPC-A**
Amanda Lorraine Cooper, **CPC-A**
Amanda Marie Stephens, **CPC-A**
Amanda McBride, **CPC-A**
Amanda McElwee, **CPC-A**
Amandeep Sangotra, **CPC-A**
Amber Corn, **CPC-A**
Amber Gray, **CPC-A**
Amber Hall, **CPC-A**
Amber Mosa, **CPC-A**
Amber Nicole Gouvion, **CPC-A**
Amber Swenink, **CPC-A**
Ambuhr Marie Hunter, **CPC-A**
Amit Nangrani, **CPC-H-A**
Amy Vickers, **CPC-A**
Amy Butts, **CPC-A**
Amy Lynn Phipps, **CPC-A**
Amy Myers, **CPC-A**
Amy Porter, **CPC-A**
Amy Sehestedt, **CPC-A**
Amy Sievers, **CPC-A**
Amy Whitaker, **CPC-A**
Ana Quevedo, **CPC-A**
Anah Parrish, **CPC-A**
Andrea Baduria Ross, **CPC-A**
Andrea Lynn Dittmar, **CPC-A**
Angel Stubbs, **CPC-A**

Angela Christina Giomi, **CPC-A**
Angela Karmazin, **CPC-A**
Angie Jellish, **CPC-A**
Anje Clayton, **CPC-A**
Ankam Avinash Kumar, **CPC-A**
Ann Burnheimer, **CPC-A**
Ann Kvasnicka, **CPC-P-A**
Ann Modlin, **CPC-A**
Ann Zabriskie, **CPC-A**
Anna Zuniga, **CPC-A**
Annamaria Caputo, **CPC-A**
Anne Morgan, **CPC-A**
Anne Parks Gilmore, **CPC-A**
Annette Schroeder, **CPC-A**
April Frost, **CPC-A**
April McQuaig, **CPC-A**
Arlene Pelletier, **CPC-A**
Arun Prasath Dhamodharan, **CPC-A**
Ashley Ann Bennett, **CPC-A**
Ashley Nicole Hughes, **CPC-A**
Ashley Zorn, **CPC-A**
Barbara Garber, **CPC-A**
Barbara J Iding, **CPC-A**
Barbara Newman, **CPC-A**
Becky Tran, **CPC-A**
Becky Dierking, **CPC-A**
Beeram Indira Sravanthi, **CPC-A**
Benjamin Peter Gould, **CPC-A**
Beth A Fink, **CPC-A**
Beth G Broadbent, **CPC-A**
Bethann Bennion, **CPC-A**
Betty Mercurio, **CPC-A**
Bhuvaneswari Kannan, **CPC-A**
Bobbi Jean Booraem, **CPC-A**
Brandi K Linthicum, **CPC-A**
Brandy Leigh Barnes, **CPC-A**
Brandy Michele Dorsch, **CPC-A**
Brandy Oliver, **CPC-A**
Brenda Fox, **CPC-A**
Brenda Kay Chiti, **CPC-A**
Brenda Pearson, **CPC-A**
Brenda Schachel, **CPC-A**
Brenda Steinhauser, **CPC-A**
Bridget Kendrick, **CPC-A**
Brinal Figer, **CPC-A**
Brittany Lovejoy-Haynes, **CPC-A**
Brittany McAbee, **CPC-A**
Brittany Zitek, **CPC-A**
Brittney Cooley, **CPC-A**
Buffy Moore, **CPC-A**
Caitlin Klaine, **CPC-A**
Cameron Lewis Trossman, **CPC-A**
Camille Banach, **CPC-A**
Camille Mortel Lalis, **CPC-A**
Candace Jayne Marley, **CPC-A**
Carissa Fisk, **CPC-A**
Carla Greenwell, **CPC-A**
Carol Gouaich, **CPC-A**
Carol Krynski, **CPC-A**
Carol Russell, **CPC-A**
CarolAnn Love-Wahlberg, **CPC-A**
Carolyn Coleman, **CPC-A**
Carrie Markel, **CPC-A**
Casandra Steinhaus, **CPC-A**
Casey Geneva Groetsch, **CPC-A**
Cassandra Betts, **CPC-A**
Catherine Jorgensen, **CPC-A**
Catherine Kraft, **CPC-A**
Cecilia Corrin Koch, **CPC-A**
Chad Scott, **CPC-A**
Charchelle Lestage, **CPC-A**
Charles Maurice Canaan, **CPC-A**
Chatarajupalee Durga Naga Malleswara Rao, **CPC-A**
Chelsea Mcdaniel, **CPC-A**
Chelsey Butterfield, **CPC-A**
Cheri Renee Mignot, **CPC-A**
Cherlynn Villa, **CPC-A**
Cheryl Casper, **CPC-H-A**
Cheryl Godfrey, **CPC-A**
Christina Marie Hopkins, **CPC-A**
Christina Villanueva, **CPC-A**
Christine Bergeron, **CPC-A**
Christine McWilliams, **CPC-A**
Christine Sicley, **CPC-A**
Christine Suzanne Darrow, **CPC-A**
Christopher Waters, **CPC-A**, CPC-H-A
Christopher Xiong, **CPC-A**
Christy Fudge, **CPC-A**
Christy Marie Frye, **CPC-A**
Chrysel DSouza, **CPC-A**
Cindy Gillespie, **CPC-H-A**
Cindy Kay Reader, **CPC-A**
Cindy Koerner, **CPC-A**
Claire Herring, **CPC-A**
Clarene Ong Abarro, **CPC-A**
Clarissa Card, **CPC-A**
Constance Coppo, **CPC-A**
Coralee A Aulder, **CPC-A**
Courtney Gonzalez, **CPC-A**
Crescent Clark, **CPC-A**
Crystal Bowman, **CPC-A**
Crystal Broadnax, **CPC-A**
Crystal Jones, **CPC-A**
Cynthia Love, **CPC-A**
Cynthia Spirk, **CPC-A**
Damon Borom, **CPC-A**
Dana C Klenz, **CPC-A**
Dana Regan-Plourde, **CPC-A**
Daniel Schwacofer, **CPC-A**
Danielle Davis, **CPC-A**
Danielle Gill, **CPC-A**
Daryl Phillips, **CPC-A**
David Arthur Craigie MD, **CPC-A**
Dawn Elizabeth Bonebrake, **CPC-A**
Dawn Sperry Quattro, **CPC-A**
Deanna Presley, **CPC-A**
Debbie Wolst, **CPC-A**
Deborah Thompson, **CPC-A**
Deborah C Stewart, **CPC-A**
Deborah Jean Coffin, **CPC-A**
Deepthivijayan Achari, **CPC-A**
Deidre Lynn Stiefel, **CPC-A**
Dena Nguyen, **CPC-A**
Denise Anne Anderson, **CPC-A**
Denise Chalmers, **CPC-H-A**
Denise Kopulos, **CPC-A**
Denise Lowther, **CPC-A**
Denise Scalf, **CPC-H-A**
Dennis Burke, **CPC-A**
Devon Taylor, **CPC-A**
Diana Jean Hopkins, **CPC-A**
Diana Meyer, **CPC-A**
Diana Richards, **CPC-A**
Diane Laczka, **CPC-A**
Diane Leslie Cook, **CPC-A**
Diane M Richman, **CPC-A**
Diane Marie Delman, **CPC-A**
Diane Muchow, **CPC-A**
Dineen Lyons, **CPC-A**
Dirk Lyn Holland, **CPC-A**
Donna Abrams, **CPC-A**
Donna C Bivona, **CPC-A**
Donna Ford, **CPC-H-A**
Donna M Para, **CPC-A**
Donna M Ulik, **CPC-A**
Dorothea Keyes, **CPC-A**
Douglas A Worley, **CPC-A**
Drew Thompson, **CPC-A**
Durishetti Mahendar, **CPC-A**
Eboni Davis, **CPC-A**
Edwina Rains, **CPC-A**
Elena Saladin, **CPC-A**
Elizabeth Lenart, **CPC-A**
Elizabeth Bonawitz, **CPC-A**
Elizabeth DaRin, **CPC-A**
Elizabeth Marie Sharpe, **CPC-A**
Emily Caryl Ulmen, **CPC-A**
Eric Dawkins, **CPC-A**
Eric Farage, **CPC-A**
Ericka Didion, **CPC-A**
Erin Elizabeth Mulcahy, **CPC-A**
Erin Holland, **CPC-H-A**
Fadila Ausbie, **CPC-A**
Faith Deffendoll, **CPC-A**
Frances Blakewell, **CPC-A**
Francesca Susan Peters-Landlord, **CPC-A**
Gabrielle Uri, **CPC-A**
Gail Waliser, **CPC-A**
Ganesh Bhoje, **CPC-A**
Gay Perdido Pineda, **CPC-A**
Geri Carsten, **CPC-A**
Gina Cruz, **CPC-A**
Gina Davis, **CPC-A**
Ginger Simmons, **CPC-A**
Giny Montalvo, **CPC-A**
Giovanna Lakomy, **CPC-A**
Gwen Strange, **CPC-A**
Halima Kaiser Khan, **CPC-A**
Heather A Houser, **CPC-A**
Heather Dolan, **CPC-A**
Heather Fuller, **CPC-A**
Heather Johnson, **CPC-A**
Heather Lynn Duval, **CPC-A**
Heather M McCracken, **CPC-A**
Heather Marie Ward, **CPC-A**
Heather Skaggs, **CPC-A**
Heidi Church, **CPC-A**
Hellweh Khoury, **CPC-A**
Hilary Dillow, **CPC-A**
Hillary Maiolino, **CPC-A**
Hollie Parker, **CPC-A**
Holly Jennings, **CPC-A**
Holly Louise Schleppenbach, **CPC-A**
Holly Ryan-Wilkinson, **CPC-A**
Holly Stafford, **CPC-A**
Hope Gesenhues, **CPC-A**
Hope Nelson, **CPC-A**
Ja'Nell Floravit, **CPC-A**
Jackie Crippen, **CPC-A**
Jacqueline Herrera, **CPC-A**
Jacqueline Mccarthy, **CPC-A**
Jacqueline Michelle St. Cyr, **CPC-A**
Jacqueline Pauline Tommila, **CPC-A**
Jade Peterson, **CPC-A**
James Wenzel, **CPC-A**
Jami Lynn Anthony, **CPC-A**
Jamie Stempien, **CPC-A**
Janet Higgins, **CPC-A**
Janice E Letteer, **CPC-A**
Janice L Fowler, **CPC-H-A**
Jasmine M Paczkowski, **CPC-A**
Jean Alling Thompson, **CPC-A**
Jeanne Gabris, **CPC-A**
Jeannie Booker, **CPC-A**
Jeannine Bumford, **CPC-A**
Jeannine Roy, **CPC-A**
Jeff Woolley, **CPC-A**
Jeffery Allen Rosenlund, **CPC-A**
Jen Renee Tucker, **CPC-A**
Jennifer Ann Copertino, **CPC-A**
Jennifer Ann Manausa, **CPC-A**
Jennifer Bauman, **CPC-A**
Jennifer Booth, **CPC-A**
Jennifer Daricek, **CPC-A**
Jennifer E Masse, **CPC-A**
Jennifer Elena Herrera, **CPC-A**
Jennifer Fischer, **CPC-A**
Jennifer Kruk, **CPC-A**
Jennifer Labonte, **CPC-A**
Jennifer Nielson, **CPC-A**
Jennifer Overholt, **CPC-A**, CPMA
Jennifer Panganiban, **CPC-A**
Jennifer Parkhurst, **CPC-A**
Jennifer Richardson, **CPC-A**
Jennifer Scarpa, **CPC-A**
Jennifer Sue Hart, **CPC-H-A**
Jennifer Sue Justus, **CPC-A**
Jennifer Verdi-Stieg, **CPC-A**
Jennifer Wingertsahn, **CPC-A**
Jenny Wheaton, **CPC-A**
Jesse F Moncayo, **CPC-A**
Jessica Caterina McCaa, **CPC-A**
Jessica Cook, **CPC-A**
Jessica Linn Witt, **CPC-A**
Jessica Parker, **CPC-A**
Jessica Ruth Hinds, **CPC-A**
Jessie Gautreaux, **CPC-A**
Jill Olson, **CPC-A**
Jill Therese Inman, **CPC-A**
Joanna Weyand, **CPC-A**
Joanne Andrews, **CPC-A**
Jodi Brown, **CPC-A**
Jody Lynn Arden, **CPC-A**
Johnna B Bedard, **CPC-A**
Joleen M Wilson, **CPC-A**
Jolene Tinlin, **CPC-H-A**
Jonathan Greenberg, **CPC-A**
Joseph Selva Raj, **CPC-A**
Josephine Ann Bartolucci, **CPC-A**
Josette Maureen Kendall, **CPC-A**
Josie Leigh Johnson, **CPC-A**
Judy Lynn Leon, **CPC-A**
Julie Daoud, **CPC-A**
Julie Wray, **CPC-A**
Julie Doherty, **CPC-H-A**
Julie Eckard, **CPC-A**
Julie Johnson, **CPC-A**
Julie Koncher, **CPC-A**
Julie Lynne Brant, **CPC-A**
Justin C. Evans, **CPC-A**
Justin Dayalan, **CPC-A**
Kaitlin Suzanne Faull, **CPC-A**
Kaitlyn Bailey, **CPC-A**
Kandace Johnson, **CPC-A**
Karen Kearns, **CPC-A**
Karen A Callahan, **CPC-A**
Karen Ames, **CPC-A**
Karen Anne Hall, **CPC-A**
Karen Barnhill, **CPC-A**
Karen Bush, **CPC-A**
Karen Gentner, **CPC-A**
Karen J Larson, **CPC-A**
Karen Klovanish Fisher, **CPC-A**
Karen Leadbetter, **CPC-A**
Karen Rogers, **CPC-A**
Karen Sue Green, **CPC-A**
Karen Wolfson, **CPC-A**
Karin Yvonne Dykes, **CPC-A**
Karla Hurraw, **CPC-A**
Karla Amahan Chan, **CPC-A**
Kate Charette, **CPC-A**
Katherine Jacobson, **CPC-A**
Kathleen Elaine Yellets, **CPC-A**
Kathleen J.M. Hansen, **CPC-A**
Kathleen Tompkins, **CPC-A**
Kathrine Lowe, **CPC-A**
Kathryn Bess Joyce, **CPC-A**
Kathryn Buchanan, **CPC-A**
Kathryn Graves, **CPC-A**
Kathryn Jean Dunagan, **CPC-A**
Kathryn Susan Madenjian, **CPC-A**
Kathy A Patrizi, **CPC-A**
Kathy Byrd, **CPC-A**
Kathy Rider, **CPC-A**
Katie Westegard, **CPC-A**
Katrina Hering, **CPC-A**
Kay Merritt, **CPC-A**
Kelli Maryann Bunch, **CPC-A**
Kellie Elizabeth McCarthy, **CPC-A**
Kellie Goode, **CPC-A**
Kenneth Kruzansky, **CPC-A**
Keri Ann DeWall, **CPC-A**
Kerianna M Millios, **CPC-A**
Kerri Apolzon, **CPC-A**
Kerry Koberowski, **CPC-A**
Kevin Saylor, **CPC-A**
Khuma Aluri, **CPC-A**
Kim Peterson, **CPC-A**
Kimberly Burrows, **CPC-A**
Kimberly Marie Bramow, **CPC-A**
Kimberly Reed, **CPC-A**
Kimberly Sue Balkema, **CPC-A**
Kirsten Lynn Pankey, **CPC-A**
Kitty Price, **CPC-A**
Kristeena Pouliot, **CPC-A**
Kristen L Bernard, **CPC-A**
Kristen Singleton, **CPC-A**
Kristian Kowsky, **CPC-A**
Kristin Lynn Ziegelmeier, **CPC-A**
Kyrstyn Rae Crandall, **CPC-A**
Lacey L Gonzales, **CPC-A**
Lais Murray, **CPC-A**
LaJarle J Borkowski, **CPC-A**
LaKeshia Maria Primeau, **CPC-A**
Lanie Abulencia Arbolado, **CPC-A**
Lanita Yoder, **CPC-A**
Larissa Crayton, **CPC-A**
Larry Wu, **CPC-A**
Latasha Mason, **CPC-A**
Latha Sogam, **CPC-A**
Latitia Angelete Sloan, **CPC-A**
Latricia Lashone Davis, **CPC-A**
Laura Aerne, **CPC-A**
Laura Duffy, **CPC-A**
Laura Hendrix, **CPC-A**
Lauren Grams, **CPC-A**
Lauren White, **CPC-A**
Laurie Ann Davis, **CPC-A**
Laurie Gibbons, **CPC-A**
Laurie Hart, **CPC-A**
Laurie N Robinson, **CPC-A**
Laurie Sue Esparza, **CPC-A**
Lavetta Bench, **CPC-A**
LaVona Marchant, **CPC-A**
Layli Nottingham, **CPC-A**
Leslie Cole, **CPC-A**
Leslie Deanne Jones, **CPC-A**
Lillian I Gonzalez, **CPC-A**
Linda Deapo, **CPC-A**
Linda L Lightner, **CPC-A**
Linda L Shepherd, **CPC-A**
Linda Rathman, **CPC-A**
Linda Seiler, **CPC-A**
Linda Yero, **CPC-A**
Lindsay Boomsma, **CPC-A**
Lindsay Brooke Parsells, **CPC-A**
Lisa Anne Donaldson, **CPC-A**
Lisa Caris, **CPC-A**
Lisa Howard, **CPC-A**
Lisa J Nieft, **CPC-A**
Lisa Jo Wolf, **CPC-A**
Lisa Katherine Gildea, **CPC-A**
Lisa Neri, **CPC-A**
Lisa Yost, **CPC-A**
Lisa Zerrlaut, **CPC-A**, CPCD
Long Truong, **CPC-A**
Lorene Ward, **CPC-A**
Lori A Stark, **CPC-A**
Lori Courtade, **CPC-A**
Lori Hasman, **CPC-A**
Lorraine Weary, **CPC-A**
Louise M Jacobs, **CPC-A**
Lourdes M Brents, **CPC-A**
Luvenia Stafford, **CPC-A**
Lynette Sue Graham, **CPC-A**
Lynn Palmatier, **CPC-A**
Lynn S Gordon, **CPC-A**
Ma Arceli B Young, **CPC-A**
Mackenzie Bruno, **CPC-A**
Maggie Ann Rowe, **CPC-A**
Mahipal Goud, **CPC-A**
Majjigapu Srinivas Reddy, **CPC-A**
Malgorzata Agacki, **CPC-A**
Malinda Wildey, **CPC-A**
Mamta Koyande, **CPC-A**
Mandy Beres, **CPC-A**
Mandy Lee Luedecke, **CPC-A**
Mandy Schaller, **CPC-A**
Marc Ryan Fillhart, **CPC-A**
Margaret Anne Shaw Valanidas, **CPC-A**
Margy Wascher, **CPC-A**
Maria Elena Blando, **CPC-A**
Maria Lorenzo, **CPC-A**
Maria Matish, **CPC-A**
Maria V Lavelle, **CPC-A**
Marina Arroyo, **CPC-A**
Marisa Lee Wentz, **CPC-A**
Marista Mcwhorter, **CPC-A**
Maritess Khayatan, **CPC-A**
Mark Andrew Rudy, **CPC-A**
Mark Wilkerson, **CPC-A**
Marquita Klinedinst, **CPC-A**
Marsha Cox, **CPC-A**
Martesia Michelle Turkalj, **CPC-A**

Martin Suelto Jr, **CPC-A**
Martina Todd, **CPC-A**
Martina Romano, **CPC-A**
Mary Hackett, **CPC-A**
Mary Usner, **CPC-A**
MarySue Kristina Nobis, **CPC-A**
Matthew McDermed, **CPC-A**
Mayur Kasar, **CPC-A**
Mayur Naik, **CPC-A**
Melanie Fuller, **CPC-A**
Melinda Webster, **CPC-A**
Melissa Fisher, **CPC-A**
Melissa Barratt, **CPC-A**
Melissa Halcomb, **CPC-A**
Melissa Montgomery, **CPC-A**
Melody L Fuller, **CPC-A**
Michael William Hoy, **CPC-A**
Michelle Rivard, **CPC-A**
Michelle Keehn, **CPC-A**
Michelle Lynn Parr, **CPC-A**
Michelle Lynn Russell, **CPC-A**
Michelle Snyder, **CPC-A**
Mikal Mullaly, **CPC-A**
Miranda Chipman, **CPC-A**
Miriam C Escamilla, **CPC-A**
Mitzi Ambrose, **CPC-A**
Mitzi O'Shea Sumner, **CPC-A**
Mohamed Thameem Cintha Nagoor Kani, **CPC-A**
Molinda Scott, **CPC-A**
Monica Reder, **CPC-A**
Monica Rodriguez, **CPC-A**
Muralidhar Choudary Meka, **CPC-A**
Myriam Lauture, **CPC-A**
NVSSN Murty Koruprolu, **CPC-A**
Nancy L Riem, **CPC-A**
Nancy Palombi, **CPC-A**
Nataliya Kurchiy, **CPC-A**, CPC-H-A
Neelam Khade, **CPC-A**
Neeraja Maram, **CPC-A**
Neha, **CPC-P-A**
Nichole Wormald, **CPC-A**
Nicole Greaves, **CPC-A**
Nicole Hall, **CPC-A**
Nicole Wing, **CPC-H-A**
Nikki Lyons, **CPC-A**, CPC-H-A
Nina Keomouangchanh, **CPC-A**
Noel Hernandez, **CPC-A**
Olianne Nicolette Tinker, **CPC-A**
Padmalatha Srinivasan, **CPC-A**
Paige Weltz, **CPC-A**
Pallavi Nagapure, **CPC-A**
Pamela Kottkamp, **CPC-A**
Pamela Rikkhi Gobin, **CPC-A**
Pat Carol Frederick, **CPC-A**
Patrice Flanagan, **CPC-A**
Patricia Swain, **CPC-A**
Patricia Haggard, **CPC-A**
Patricia Nevarez, **CPC-A**
Paul Anthony Hoo-Fong, **CPC-A**
Paula Beaman, **CPC-A**
Paula Gossett, **CPC-A**
Paula Turtura, **CPC-A**
Pavani Boragani, **CPC-A**
Peggy Ochranek, **CPC-A**
Penny E Stipes, **CPC-A**
Penny Johnson, **CPC-A**
Penny Riser, **CPC-A**
Peter Rayner, **CPC-A**
Prafulla Jadhav, **CPC-A**
Prakash Sundarababu, **CPC-A**
Prathmesh Shirsath, **CPC-A**
Preciousness McCorvey, **CPC-A**
Premalatha Sundararajan, **CPC-A**
Priscilla Rivas, **CPC-A**
Radha Lakshmi Karumuri, **CPC-A**
Radhika Rapalli, **CPC-A**
Rajathilagam Ramamurthy, **CPC-A**
Rajib Koner, **CPC-A**
Ramesh Raj Ramaraj, **CPC-A**
Ranjit Singh, **CPC-A**
Ratish Radhakrishnan Nair, **CPC-P-A**
Rebecca Andrade, **CPC-A**
Rebecca H Davenport, **CPC-A**
Rebecca J Lonergan, **CPC-A**
Rebecca R Marcum, **CPC-A**
Rebecca Reese, **CPC-A**
Regan Earle, **CPC-A**
Regina Park, **CPC-A**
Renee Cottrill, **CPC-A**
Renee Lehman Milton, **CPC-A**
Renee Ortiz, **CPC-A**
Rhonda Kay Nord, **CPC-A**
Richard J Sughrue III, **CPC-A**
Richard Miller, **CPC-A**
Rita Ann Sagrillo, **CPC-A**
Rita Salekar, **CPC-A**
Robelyn Pounds, **CPC-A**
Robert Kelleher, **CPC-A**
Robin Clark, **CPC-A**
Robyn Alicia McCoy-Clark, **CPC-A**
Robyn Marie Curtin, **CPC-A**
Rochelle Elie, **CPC-A**
Rochelle Ramos Mitchell, **CPC-A**
Rodolfo Alba, **CPC-A**
Rohini Jhadav, **CPC-A**
Rokesha Verletta Simmons, **CPC-A**
Ronda Watts, **CPC-A**
Rosalia Zerilli, **CPC-A**
Rosana Lasara Davalos-Ramirez, **CPC-A**
Rose Abraham, **CPC-A**
Rose Marie Lizarraga, **CPC-A**
Rosemarie Faust, **CPC-A**
Roslyn Thompson, **CPC-A**
Runeet Aulakh, **CPC-A**
Russell Thomas Ogren, **CPC-A**
Ruth Ann Palmer, **CPC-A**
Ruth Lloyd, **CPC-A**
Ryan Marie Sherman, **CPC-A**
Sagayamary Nadar, **CPC-A**
Samantha Jo Robertson, **CPC-A**
Samantha King, **CPC-A**
Samantha Lee Foye, **CPC-A**
Sandra L Miele, **CPC-A**
Sandra St Clair, **CPC-A**
Santosh Kumar, **CPC-P-A**
Sara Ann Aurand, **CPC-A**
Sara Eicher, **CPC-A**
Sara Elizabeth Clark, **CPC-A**
Sara Frischer, **CPC-A**, CPC-H-A
Sara Labieniec, **CPC-A**
Sara Renee Boren, **CPC-A**
Sarah Ellen Fredriksen, **CPC-A**
Sarah Farrell, **CPC-A**
Sarah Kummer, **CPC-A**
Sarah Marchand, **CPC-A**
Satya Shyamala Tarigoppula, **CPC-A**
Scharre Henry, **CPC-A**
Senta Sue Alden, **CPC-A**
Sergio P Rodriguez, **CPC-A**
Shahnila Baqai, **CPC-A**
Shaik Rahana Begum, **CPC-A**
Shakuntala D. Patel, **CPC-A**
Shannon Jay Griffin, **CPC-A**
Shantell Reeve, **CPC-A**
Shanthala Murthy, **CPC-A**, CPC-H-A
Sharon Stanley, **CPC-A**
Sharon Gleitz, **CPC-A**
Sharon Mumfrey, **CPC-A**
Sharon Nicole Russell, **CPC-A**
Sharon Parker, **CPC-H-A**
Sharon Steel, **CPC-A**
Shelly Brinkley, **CPC-A**
Sherrie Edington, **CPC-A**
Sherrie Vanover, **CPC-A**
Sherry Langbein, **CPC-A**
Sherry Bright, **CPC-H-A**
Shirley A Baker, **CPC-A**
Siddhesh Nalvade, **CPC-A**
Sierra Spears, **CPC-A**
Silvia Fernandez, **CPC-A**
Silvia Molina, **CPC-A**
Sivaraman Sivasubramanian, **CPC-A**
Skye Kerr, **CPC-A**
Sony Manchimsetty, **CPC-A**
Sreedevi Golla, **CPC-A**
Srinivas Reddy Nadide, **CPC-A**
Stacey Church, **CPC-A**
Stacy Henderson, **CPC-A**
Stacy L Mcgarry, **CPC-A**
Stacy Smith, **CPC-A**
Stefanie Lynn Wilson, **CPC-A**
Stephanie Alvey, **CPC-A**
Stephanie Darlene Taylor, **CPC-A**
Stephanie Estes, **CPC-A**
Stephanie Lange, **CPC-A**
Stephanie Marie Janssen, **CPC-A**
Stephanie Olivia Schlosser, **CPC-A**
Stephanie Wieland, **CPC-A**
Stephenie Boisvert, **CPC-A**
Steven Si, **CPC-A**
Suchitra Samuel, **CPC-A**
Sukanya Parthsarathy, **CPC-A**
Sule Mohammed, **CPC-A**
Supriya Thakur, **CPC-A**
Suruchi Koli, **CPC-A**
Susan Corona, **CPC-A**
Susan Elizabeth Smith, **CPC-A**
Susan Tallarico, **CPC-A**
Susanne McCarthy, **CPC-A**
Suzanne Stumpff, **CPC-A**
Suzette Spencer, **CPC-A**
Syed Guffar, **CPC-A**
Syed IfthequarAhmed, **CPC-A**
Talia Adelaide Hamilton, **CPC-A**
Tamala Robinson, **CPC-A**
Tamara J Hendrickson, **CPC-A**
Tamesha Bowens, **CPC-A**
Tamika Yearwood, **CPC-A**
Tammy Howell, **CPC-A**
Tammy Zoch, **CPC-A**
Tara John, **CPC-A**
Tara Samantha Baxter, **CPC-A**
Tarah A Hess, **CPC-A**
Tasha Lyn Ford, **CPC-A**
Taslim Arif Baksh, **CPC-A**
Taylia Norcini, **CPC-A**
Tejashree Laxman Patil, **CPC-A**
Teresa Nash, **CPC-A**
Teri Godfrey, **CPC-A**
Terri L Raub, **CPC-A**
Terry Beach, **CPC-A**
Theresa Berry, **CPC-A**
Thomas Karamintzas, **CPC-A**
Tiffany LaFontaine, **CPC-A**
Toni Fryer, **CPC-A**
Tonya Rae Gaskill, **CPC-A**
Toyasileste Fowler-Tarver, **CPC-A**
Tracy Audet, **CPC-A**
Tracy Irene Otto, **CPC-A**
Tracy Marcotte, **CPC-A**
Tralisa Rae Kettner, **CPC-A**
Travis Draper, **CPC-A**
Twila Bally, **CPC-A**
Ursula Zettlemoyer, **CPC-A**
Vanessa May Blom, **CPC-A**
Vanessa Verna, **CPC-A**
Varun Joy, **CPC-H-A**
Vernay Canty, **CPC-A**
Veronda Mciver-Haley, **CPC-A**
Vicki Layman, **CPC-A**
Victoria Chalut, **CPC-A**
Victoria Whisinnand, **CPC-A**
Vijay Chandragiri, **CPC-A**
Vinay Jaligam, **CPC-A**
Vincent Allen, **CPC-A**
Vinh Nguyen, **CPC-A**
Vishal Bhujbal, **CPC-A**
Wendy A Quartuccio, **CPC-A**
Wendy Jean Shreve, **CPC-A**
Wendy Klug, **CPC-A**
Winnie Chan, **CPC-A**
Yolanda Barry, **CPC-A**
Yolonda Williams, **CPC-A**
Yuen-Man Kwan, **CPC-A**
Yvonne Dundee, **CPC-A**
Yvonne Stults, **CPC-A**

Specialties

Alicia Montes, **CPCD**
Amy Prower, CPC, **CGIC**, CGSC, CPCD
Angela Rogers, **CIRCC**
Angela Short, **CPCD**
Ann Linton, CPC, **CUC**
Anna M Morissette, CPC, **CGSC**
Ashley Lynch, CPC, **CPMA**
Audrey Fox, CPC, **CPMA**
Audrey Maureen Steinke, CPC, **CFPC**
Avis Evans, **CPMA**, CEDC
Barbara Addington, **CIRCC**
Bianca Bunyea, **CPCO**
Bonita Elmer, CPC, **CHONC**
Brian Goldsberry, **CHONC**
Candace Smith, **CEDC**
Cara Cross, **CPMA**
Caroline A Barnett, CPC-A, CPC-H-A, CPC-P-A, **CASCC**, CHONC
Catherine S Nest, CPC, CEMC, **COBGC**
Chalantha Catrese Lewis, CPC, **CCVTC**
Christi Kempf, **CPCD**
Christina Conway, **CPMA**
Christine Hunt, **CPEDC**
Christine R Carbonaro, CPC, CPC-P, **CPMA**
Christopher E Schulze, CPC-H, **CPMA**
Cindy L Opp, CPC, **CPMA**
Cindy L Swan, CPC, **CEMC**
Corrie Renee Burr, CPC, **CFPC**
Daimy Diaz, CPC, **CPMA**
Daisy Webster, CPC, CPC-H, **CPMA**, CPC-I
Denise Brock, **CEDC**
Denise Nitti, **CPCD**
Diana Plocica, **CEMC**
Dorice Heron, **CANPC**
Eileen Rasche, **CIMC**
Elena M Luzarraga, CPC-A, **CPMA**
Elizabeth Martinez, **CUC**
Eric J McCalla, CPC, **CCC**
Erin Price, **COBGC**
Genevieve Hall, **CPMA**
Gerald Stewart Ross, **CPCO**
Grace Richardson, CPC, **CPMA**
Heather Kostoff, CPC, **CPMA**
Heather Lynn Ertel, CPC, **COSC**
Jamie Elizabeth Frantz, CPC, **CEMC**
Jason W Donnelly, CPC, CASCC, **CEDC**
Jeanette Sprogis-Lajoy, CPC, **CPMA**
Jeanine Whipple, CPC, **CHONC**
Jennifer Donaghue, **CPCD**
Jennifer G Sheese, CPC, CPC-H, **CEDC**
Jennifer Hall, CPC, **CPMA**
Jennifer Holland, CPC, **CIRCC**
Jennifer Lynn Hendrix, CPC, **CPMA**
Jennifer Scholler, **CANPC**
Jessica A Ravello, CPC, **CPMA**
Jessica Cope, CPC, **CEDC**
Jill Stefka, CPC-H, **CHONC**
Jo Ann Hawtrey, CPC, **CUC**
JoAnne Caporaso, CPC, **CPMA**
Jodie Renee Ellis, **CASCC**
Joseph E Newsome HCS, HAS, CPC, CPC-H, CPCO, **CPMA**, CPC-I, CEMC
Judy Boutilier, CPC, **CPCO**
Judy Gullord, CPC, **CPMA**
Judy H Webster, CPC, **CPCO**
Karen Welsh, **CPMA**
Katherine Iva Hopkins, CPC, **CPMA**, CEDC
Kathy Hall Leap, CPC, CPC-H, CEMC, **COBGC**
Kelly Jo Moore, CPC, **CEMC**
Kimberly Lima, **CPMA**
Kira Diane Flint, CPC, **CEDC**
Kristi Reismann, CPC-A, **CEMC**
Laura McNamara, CPC, **CPMA**, CEMC
Lea Yoakem, **CPMA**
Leidy Romis Arguelles, CPC, **CPMA**
Leslie Huck, CPC, **CPCO**, CPC-P, CPMA
Linda I Vallery, CPC, **CIRCC**
Linda S Reese, CPC, **CPMA**
Lindsay Renee Mikkola, CPC, **CPMA**
Lisa Burke, **CPEDC**
Lorena Wilhoite, **CPCD**
Lori Henderson, **CEMC**
Manny St James, **CIRCC**
Maria Germano, CPC, **CPEDC**
Marika Butler, **CFPC**
Marilyn Kitchens Cecil, CPC, **CPCD**, CPRC
Megan K Piffer, CPC, **CPMA**
Melissa Bailey, CPC, **CEMC**
Melissa Lee Tescher, CPC, **CPMA**, CEMC
Melissa Lucas, **CHONC**
Melody Ketterer, **CPCD**
Michael Loss, CPC, **CPMA**
Michelle Jean Bartoszek, CPC, CFPC, **CIMC**
Michelle Stanek, **CPMA**
Michelle Weiss, **CHONC**
Olena Krechkivska, **CPCD**
Patricia Trautner, CPC, CEDC, **CHONC**
Rachel Pecchi, **CPCD**
Reanie Greer, CPC, **CEDC**
Rebecca Leeper, CPC, **CEMC**
Renee L Kester, CPC, **CIRCC**
Rhonda Rene Higgins, CPC, **CPMA**
Roxanna Menger, CPC, **CPCO**, CPMA, CEMC
Sarah J Kneefel, CFPC, **CGIC**
Sharon Marie Clark, **CPEDC**
Sharon Wenona Cox, **CUC**
Sheila Ann Anderson, **CPCD**
Shelly K MacInnes, CPC, **CHONC**
Sherri L Duncan, CPC, **CHONC**
Sherri Vertrees, CPC, CPC-H, **CHONC**
Sherry Lynn Sirois, CPC-H, **CPMA**
Susan Nichole White-Fisher, CPC, **CEMC**
Suzanne Merino, CPC, **COBGC**
Tabytha L Muehlfeld, CPC, **COSC**
Tari Wainio, **CHONC**
Teressa L Cooper, **CHONC**
Terri Lyn Blevins, CPC, **CPMA**
Theresa Lyn Vinson, CPC, **CPMA**
Tiffany Morgan, CPC, **CPCO**, CPMA, CEMC
Tina R Wadkins, CPC, **CPCO**, CPMA
Tracy Smith, **CHONC**
Tricia J Prater, CPC, **CPMA**
Trudy Hallahan, **CHONC**
Valerie J Clark, CPC, **CPCO**
Verlyn Paceley, CPC, **CPMA**
Wendy A Bartko, CPC, **CPCO**, CPMA, CEMC

Magna Cum Laude

Annette Shields, **CPC**
Bhoomika Singh, **CPC**
Christine Smith, **CPC-A**
Daphne Belinda Smith, **CPC**
Debbie R Johnson, **CPC**
Dena L Morris, **CPC**
Hani El-Abbasi, **CPC-A**
Jamie Bevan, **CPC-A**
Jennifer Rene Spershteyn, **CPC**
Joshua A Elmore, **CPC-A**
Judy Markanich, **CPC**
Kathleen Hein, **CPC-A**
Kristen Winters, **CPC-A**
Kristin Jane Piper, **CPC-A**
Laura Ann Ceccorulli, **CPC-A**
Linda Jennings Moser-DuCote, **CPC-A**
Maria Glencer, **CPC-A**
Megan Nikole Artman, **CPC-A**
Michelle Lee Cumm, **CPC-A**
Nicole Buck, **CPC-A**
Pamela Shumway, **CPC-A**
Priti Nehete, **CPC-A**
Pushpalata Phapale, **CPC-A**
Robin Mayes, **CPC-A**
Ruth E Perkins, CPC, **CPMA**
Sakthivel Marudhanayagam, **CPC-A**
Sarah Noel (Bradford), **CPC-A**
Susan Diane Cook, **CPC**
Suzannah Moore, **CPC-A**
Ujwala Deshmukh, **CPC-A**
Venkata Krishnan Sivan, **CPC**

A&P Quiz Answer

Correct answer is D: Dust mites. Dust mites are considered an allergen, not a respiratory irritant.

New CEU Policy for Specialty Credential Holders

Members who hold both a CPC®, CPC-H®, CPC-P®, CPMA®, and/or CPCO™ credential (hereafter defined as Core credentials) and one or more specialty credentials will now (effective for renewals due on or after Oct. 1, 2012) be able to apply earned, pre-approved specialty CEUs toward their core credential (CEU requirements. AAPC is approving this because specialty approved CEUs are also approved for core credentials. This should save members time and money in the future. The CEU Tracker will be modified to easily enable the recording of CEUs; and instructions on how to use it will be posted by Sept. 1, 2012. Details include:

- Pre-approved specialty CEUs, effective Oct. 1, 2012 can be applied toward one specialty and one core credential concurrently.
- Specialty CEUs can be applied toward core credentials (CPC®, CPC-H®, CPC-P®, CPMA®, and CPCO™); core CEUs cannot be applied toward specialty credentials because they are not specialty approved.
    - Any pre-approved specialty CEUs can be applied toward the CPC®, CPC-H®, and CPC-P®.
    - Specialty CEUs applied toward the CPMA® or CPCO™ must be pre-approved for both the specialty and CPMA® or CPCO™ credentials.
    - Members are still required to meet the 24 required CEUs relative to and pre-approved for the CPMA® and CPCO™ credentials. (**www.aapc.com/medical-coding-education/help/index.aspx**)
- You cannot apply core CEUs toward multiple core credentials.
- Specialty CEUs cannot be applied toward the CIRCC® or CPPM™ credentials.
- Specialty CEUs cannot be used simultaneously toward another specialty credential CEU requirement.
- There is a minimum requirement of 36 unique education hours spent for any combination of credentials held.
- Total CEUs due (every two years) remain the same as in current policy:
    - 36 CEUs for one core or specialty credential
    - 48 CEUs for two credentials (16 in specialty if one is specialty or 24 if one is CPMA® or CPCO™)
    - 60 CEUs for three credentials (16 in specialty if one is specialty or 24 if one is CPMA® or CPCO™)
    - 72 CEUs for four credentials (16 in specialty if one is specialty or 24 if one is CPMA® or CPCO™)
    - 80 CEUs for five or more credentials (16 in specialty if one is specialty or 24 if one is CPMA® or CPCO™)

Examples

Two credentials—Ms. Smith holds both the COBGC™ and CPC®. She has a total of 48 CEUs due, 16 of which need to be COBGC™ specific. She attends a 2-day OB/GYN workshop worth 16 CEUs to meet her COBGC™ requirements. She also applies the same 16 CEUs toward her CPC®, leaving her with 16 CPC® CEUs to obtain. However a minimum of 36 unique education hours must be obtained. Instead of Ms. Smith having only 16 CEUs to obtain, which would total 32 education hours, she must get 20 additional CEUs for her CPC® to meet the minimum requirement of 36 unique education hours. Total CEU hours earned = 52. Hours spent = 36.

Three credentials—Ms. Jones holds the CPC®, CCC™, and CASCC™. She has a total of 60 CEUs due—16 CEUs need to be CCC™ specific and 16 need to be CASC™ specific. She attends a number of different events, meeting both her CCC™ and CASCC™ requirements (32 CEUs). She applies 16 CEUs toward her CCC™, 16 CEUs toward her CASCC™. The same 32 CEUs (CCC™ and CASCC™) are also applied to CPC® credential, covering the 28 CEUs needed for the CPC®. To meet the minimum requirement of 36 hours spent, she will need to obtain four more CEUs. She does this by completing *Coding Edge* Test Yourself quizzes. Total CEU hours earned = 60. Hours spent = 36

Four credentials—Mr. Johnson holds the CPC®, CPMA®, CANPC™, and CRHC™. He has a total of 72 CEUs due—16 must be CRHC™, 16 must be CANPC™, and 24 must be CPMA™. He attends two 2-day conferences, obtaining all of his CANPC™ and CRHC™ CEUs (total 32). The same 32 CEUs also applies toward his CPC®, which completes his CPC® requirement. He also attends a 3-day conference to get his 24 CEUs for the CPMA® credential. Total CEU hours earned = 72. Hours spent = 56.

OPTUM™

12TH ANNUAL OPTUM ESSENTIALS
CODING, BILLING, & COMPLIANCE CONFERENCE

November 26–28, 2012 | Bellagio, Las Vegas

Optum Essentials Conference:

All the coding, billing, and compliance insight you expect, plus the ICD-10 guidance you need.

The deadline for converting to ICD-10 is still looming. That's why the content, structure, and price of this year's Optum Essentials conference is designed to help you make a smooth transition to ICD-10 and streamline your day-to-day processes.

Unparalleled content

No other conference offers such a robust curriculum headed by nationally recognized experts on medical coding, billing, and compliance. Get inside—and first-to-market—information on medical code updates, regulatory changes, and compliance issues and gain the insight you need to keep your coding skills current and relevant.

Complimentary ICD-10 assessment

Registered attendees will get a complimentary ICD-10 pre-assessment so you know exactly where your organization stands in regards to the deadline. Once you know what you need, you can tailor the courses you take to make the most of your conference experience and take the right steps at the right time for a quick and easy conversion.

Early-bird discount

Registration Fee: ~~$675~~ $575. Save $100 when you register before July 31, 2012. Mention source code 150811.

Register today

Call: Mark Bourne, **801.982.3338**
email: mark.bourne@optum.com
Visit: OptumCoding.com/Essentials

November 26–28, 2012 | Bellagio, Las Vegas

Need more reasons to attend?
This year's Essential Conference will be held at The Bellagio, with special discount rates for attendees.

THE BELLAGIO® LAS VEGAS

Designed to induce a profound sense of well-being, this AAA Five Diamond Award-winning resort is both chic and luxurious. Take a stroll through our Conservatory & Botanical Gardens and relax in the comfort of nature. From the Dancing Fountains and *Cirque du Soleil®* to the gallery of fine art, the Bellagio is infused with graceful aesthetics inspired by the natural wonders of the world.

INGENIX®

Ingenix is now OptumInsight™, part of Optum —a leading health services business.

NAMAS 4th Annual Auditing Conference

A National Conference Built Exclusively for Auditors

Enhancing Your Career Through Education

Grove Park Inn Asheville, NC
December 3-4, 2012
Visit our website for full agenda and list of speakers

Early Bird Registration—

Free ticket to Biltmore Estate with dinner and candlelight tour on December 3, 2012 are going fast! Be sure to register today to get your free ticket.

DEADLINE—July 31, 2012

AAPOL (American Academy of Provider Offices and Laboratories) will be offering two educational tracks for CLIA and OSHA regulations. For more information call AAPOL at 800-470-9605

Special Pre-Conference Events

CPMA® Training— 2 day course to prepare for the CPMA® exam

CPMCN® Training—Our newest credential—2 day course to get you certified as a professional managed care negotiator

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