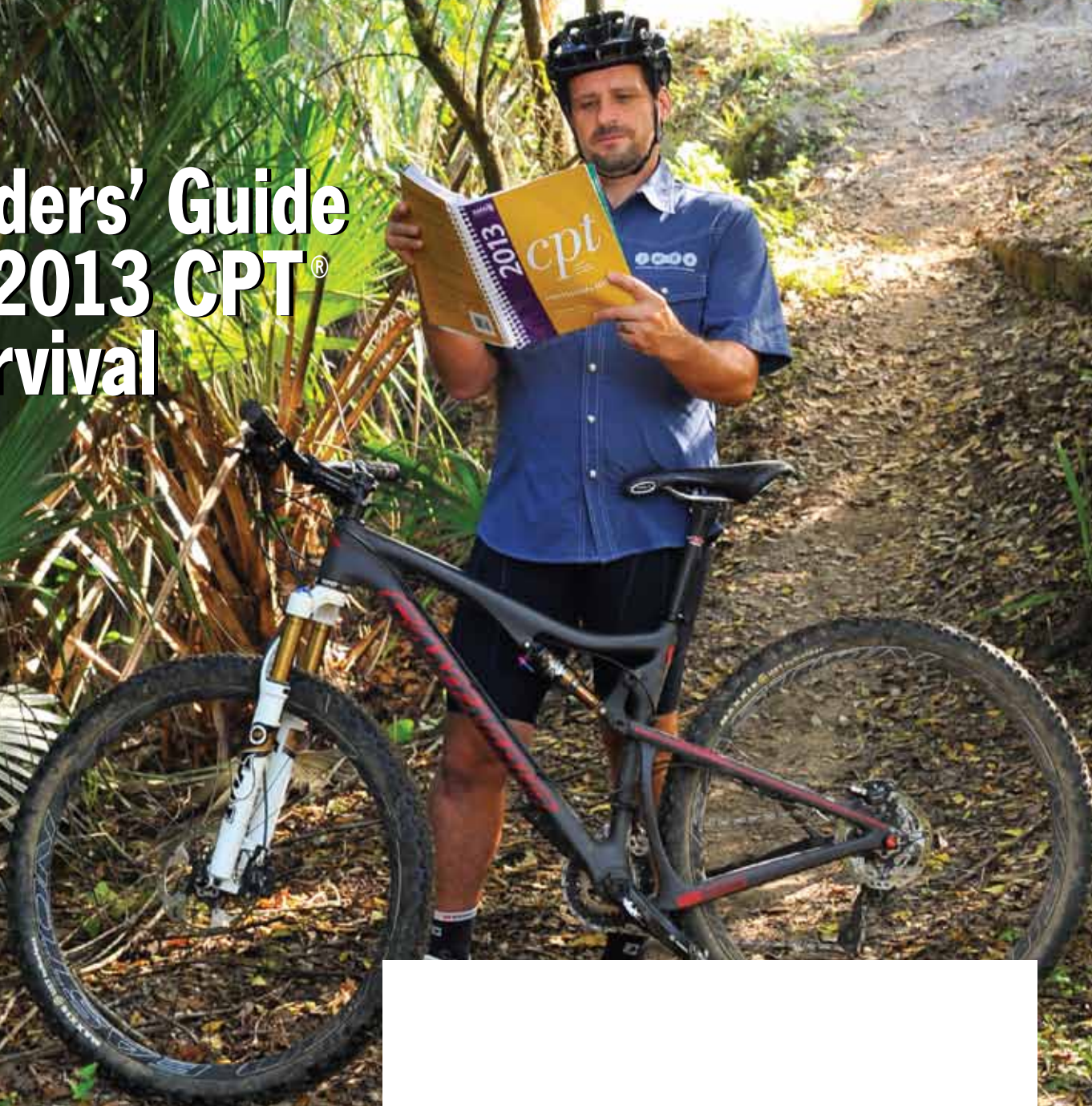


December 2012



CODING edge

Coders' Guide to 2013 CPT® Survival



G.J. Verhovshek, MA, CPC

Plus: ERCP • Multiple Endoscopy • Chicago Conference • Manage Revenue • Unlisted Procedures

2013 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

* Deposits are non-refundable

2013 Class Date	Class Location
1/24 - 1/25	Knoxville, TN
2/6 - 2/7	Savannah, GA
2/20 - 2/21	Fairfax, VA
3/4 - 3/5	Phoenix, AZ
3/7 - 3/8	San Diego, CA
3/20 - 3/21	Memphis, TN
3/27 - 3/28	New York, NY
4/4 - 4/5	Biloxi, MS
4/12 - 4/13	Orlando, FL
4/24 - 4/25	Johnson City, TN
5/1 - 5/2	Montgomery, AL
5/8 - 5/9	Madison, WI
5/15 - 5/16	Charleston, SC
6/3 - 6/4	Anchorage, AK
6/6 - 6/7	Spokane, WA
6/19 - 6/20	Indianapolis, IN
6/27 - 6/28	Wilmington, NC
7/9 - 7/10	Las Vegas, NV
7/15 - 7/16	Boise, ID

2013 Class Date	Class Location
7/18 - 7/19	Bismarck, ND
7/24 - 7/25	Dallas, TX
7/31 - 8/1	Cambridge, MA
8/12 - 8/13	Atlantic City, NJ
8/15 - 8/16	Pittsburgh, PA
8/21 - 8/22	Miami, FL
8/26 - 8/27	Salt Lake City, UT
8/29 - 8/30	Portland, OR
9/4 - 9/5	Louisville, KY
9/16 - 9/17	Lansing, MI
9/19 - 9/20	Bangor, ME
9/30 - 10/1	Albuquerque, NM
10/3 - 10/4	San Francisco, CA
10/10 - 10/11	Knoxville, TN
10/16 - 10/17	Kansas City, MO
10/23 - 10/24	Hartford, CT
11/5 - 11/6	Cleveland, OH
11/11 - 11/12	Chicago, IL
12/7 - 12/8	Atlanta, GA

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

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



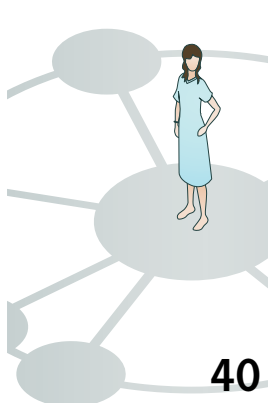
20

Facility



22

Audit/Compliance



40

Practice Management

[contents]



26

Features

- 16 Learn Why and How to Apply the Multiple Endoscopy Rule**
G.J. Verhovshek, MA, CPC
- 18 Successfully Report ERCP and Related Procedures**
Laurette Pitman, RN, CPC-H, CGIC, CCS
- 20 Hospital Coding: It Isn't Just for Inpatients**
Catrena Smith, CPC, CCS, CCS-P, and Elizabeth Giustina, CCS-P
- 22 Get Ready: The RACs Are Coming!**
Amy Lee Smith, MBA, CPC, CPC-H, CPMA, CIA, CRMA
- 26 CPT® 2013 Preview: Find Your Way in a Changing Landscape**
Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC, and G.J. Verhovshek, MA, CPC
- 33 Manage Four Key Revenue Cycle Metrics**
Jim Denny, MBA
- 36 Contracts: Prepare and Analyze Data**
Marcia Brauchler, MPH, CPC, CPC-H, CPC-I, CPHQ
- 40 Health Care Quality and Value: The (R)evolution of the ACO**
Stephen C. Spain, MD, FAAFP, CPC
Angela "Annie" Boynton, BS, CPC, CPC-H, CPC-P, CPC-I, RHIT, CCS, CCS-P, CPhT
- 44 Avoid Denials when Reporting Unlisted Services and Procedures**
John S. Aaron, Jr., CPC



CODING

edge

December 2012

In Every Issue

- 7 Letter from the Chairman and CEO**
- 9 Letter from Member Leadership**
- 10 Letters to the Editor**
- 12 AAPCCA: Festive Fun; Scholarships**
- 14 Coding News**

Special Features

- 42 AAPC Regional Conference**
- 50 Minute with a Member**

Education

- 14 A&P Quiz**
- 46 Newly Credentialed Members**

Online Test Yourself – Earn 1 CEU
Go to: www.aapc.com/resources/publications/coding-edge/archive.aspx

Coming Up

- **OIG Work Plan**
- **Cardiology**
- **Bedsore**
- **Mental Health**
- **OPPS Final Rule**

On the Cover: As John Verhovshek, MA, CPC, bikes through Caloosahatchee Regional Park in Alva, Fla., he's reminded that the best way to navigate through yearly procedural coding changes is with CPT® 2013. Cover photos by Molly Brock Photography (www.mollybrockphotography.com).

Serving 119,000 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 home or office than paper issues.

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

advertising index

American Medical Association	11
www.amabookstore.com	
American Society of Anesthesiologists	35
www.asahq.org/Coding13	
CodingWebU.com.....	39
www.CodingWebU.com	
Contexo Media	32
www.contexomedia.com	
HealthcareBusinessOffice, LLC	24
www.HealthcareBusinessOffice.com	
Ingenix is now OptumInsight,™ part of Optum™	25
www.optumcoding.com	
Medicare Learning Network® (MLN)	8
Official CMS Information for Medicare Fee-For-Service Providers	
http://www.cms.gov/MLNGenInfo	
NAMAS/DoctorsManagement	2, 15
www.NAMAS-auditing.com	
The Centers for Medicare & Medicaid Services	5
www.cms.gov	
The Coding Institute, LLC	13
www.SuperCoder.com	
ZHealth Publishing, LLC	51
www.zhealthpublishing.com	



Chairman and CEO

Reed E. Pew
reed.e.pew@aapc.com

Vice President of Finance and Strategic Planning

Korb Matosich, MBA
korb.matosich@aapc.com

Vice President of Marketing

Bevan Erickson
bevan.erickson@aapc.com

Vice President of ICD-10 Education and Training

Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, COBGC, CPEDC, CENTC
rhonda.buckholtz@aapc.com

Vice President of Live Educational Events

Bill Davies, MBA
bill.davies@aapc.com

Directors, Pre-Certification Education and Exams

Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC
raemarie.jimenez@aapc.com
Katherine Abel, CPC, CPMA, CPC-I, CMRS
katherine.abel@aapc.com

Director of Member Services

Danielle Montgomery
danielle.montgomery@aapc.com

Director of Publishing

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

Managing Editor

John Verhovshek, MA, CPC

Editorial and Production Staff

Michelle A. Dick, BS
Renee Dustman, BS
Tina M. Smith, AAS

Advertising/Exhibiting Sales Manager

Jamie Zayach, BS
jamie.zayach@aapc.com

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

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

©2012 AAPC, Coding Edge. All rights reserved. Reproduction in whole or in part, in any form, without written permission from AAPC is prohibited. Contributions are welcome. Coding Edge is a publication for members of AAPC. Statements of fact or opinion are the responsibility of the authors alone and do not represent an opinion of AAPC, or sponsoring organizations. Current Procedural Terminology (CPT®) is copyright 2011 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT®. The AMA assumes no liability for the data contained herein.

CPC®, CPC-H®, CPC-P®, CPCO™, CPMA® and CIRCC® are registered trademarks of AAPC.

Volume 23 Number 12

December 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.

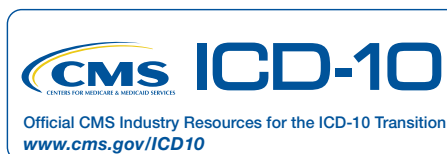


**NEW
ICD-10 DEADLINE:
OCT 1, 2014**

2014 COMPLIANCE DEADLINE FOR ICD-10

The ICD-10 transition is coming October 1, 2014. The ICD-10 transition will change every part of how you provide care, from software upgrades, to patient registration and referrals, to clinical documentation, and billing. Work with your software vendor, clearinghouse, and billing service now to ensure you are ready when the time comes. ICD-10 is closer than it seems.

CMS can help. Visit the CMS website at www.cms.gov/ICD10 for resources to get your practice ready.



2013 NATIONAL CONFERENCE **ORLANDO, FL**

APRIL 14 - 17 | Up to 18 CEUs | 70+ Sessions



**2013 AAPC
NATIONAL CONFERENCE**
Walt Disney World Resort - Florida



**SAVE
\$100!**

REGISTER BY JANUARY 23!

EARLY BIRD PRICE: \$745 FOR MEMBERS

Disney's Coronado Springs Resort

www.aapc.com/orlando2013



AAPC Year in Review

As we close out 2012, let's review what the year has brought AAPC as coding professionals and Americans.

ICD-10-CM Implementation Postponed

ICD-10 was postponed, debated, and then delayed one year to begin Oct. 1, 2014. This was undoubtedly the most important decision affecting coders and health care this year. We now have a little less than two years to prepare fully.

2012 Shout Out for AAPC

AAPC membership will approach 120,000 members by the end of the year, which is up 8 percent from 2011. We certainly appreciate your support and professionalism.

We put on two conferences this year, our national conference in Las Vegas and our fall regional conference in Chicago, which together drew more than 3,000 attendees. We hope all who attended had a great time. We're working very hard to prepare for an even better national conference next year in Orlando at Disney's Coronado Springs Resort on April 14-17. The agenda will include ICD-10 code set tracks, practice management, compliance and auditing sessions, and the usual bevy of coding sessions.

Between our National Advisory Board (NAB), the AAPC Chapter Association (AAPCCA) Board of Directors, and AAPC employees, we visited and spoke at over 100 chapters this year. We are happy to do this, so please let us know if you'd like us to visit your chapter.

AAPC introduced another new credential this year, the Certified Physician Practice Management (CPPM®) credential, which has been well received. We are planning on having boot camps around the country, as well as training courses, in 2013 to prepare people for the exam.

AAPC made a significant policy change on continuing education units (CEUs) for its specialty coding credential holders this year: We now allow CEUs taken for a specialty credential to also count towards the Certified Professional Coder (CPC®) credential.

More News for Coders

The American Medical Association (AMA) announced over 700 CPT® changes for 2013, more than in many years past. I think this was to offset the freeze in ICD-9-CM codes (lol).

A survey of more than 13,000 physicians was completed by the Physicians Foundation. You can see it on our website in the news section of our homepage or by following the link: <http://news.aapc.com/?p=21757>. The survey reflects the frustration physicians feel regarding the challenges of practicing medicine today, but also notes the joy they receive from treating patients. I recommend it as a good read to help you better understand today's health care issues and how they will potentially affect your future.

Count Your Blessings

And lastly, but most importantly, I hope everyone has a joyful and peaceful holiday season. My family grew by one this year and there will be 20 in our home over the holidays—11 of them are grandchildren. My cup overflows with blessings and I wish the same blessings for each of you.

Merry Christmas,



Reed Pew
Chairman and CEO





ACOs

Medicare
Learning
Network

Official CMS Information for
Medicare Fee-For-Service Providers

Coordinated service...better care.

Accountable Care Organizations.

When doctors, hospitals and suppliers work together, they can provide seamless, high-quality care more efficiently. Discover what providers need to know with the free fact sheet, *Accountable Care Organizations (ACOs): What Providers Need to Know*, from the Medicare Learning Network® (MLN).

Learn how participation in the Medicare Shared Savings Program rewards groups of Medicare Fee-For-Service Providers and suppliers.

Start learning now. <http://go.cms.gov/MLN-ACO>

Check out CMS on



flickr



Cherish the Gifts of Membership

Many of my previous letters have expounded the many benefits AAPC membership brings to us. I've explained that membership brings educational opportunities, credibility and recognition in the health care industry, and networking with others who value our profession and one another.

Hold Dear Your AAPC Family

There is an additional benefit this season begs me to address: the friends you make along your AAPC journey. Though you may only see them occasionally, at chapter meetings, workshops, or conferences, these fellow members have become your AAPC family.

Through the AAPC, I have met members who have become very dear friends and who have challenged and supported me in every way possible. We have watched each other's children grow into adults and our careers change and develop through the years into what they are today. These women and men have become the compass by which I navigate through my life and career path changes, keeping me focused and always moving forward.

Whether AAPC membership has led you to your dearest friend, or if you have brought them along the way with you, this holiday season please be sure to remind them of how very special they are in your life.

A Holiday Coding Gift to You

In the true spirit of the holidays, I am sharing an ICD-10 coding gift that was given to me in hopes that you will enjoy it as much as I did. Thank you, **Annie Boynton, BS, CPC, CPC-H, CPC-P, CPC-I, RHIT, CCS, CCS-P, CPhT**. Your clever mind, generosity, and humility have no limits.

"Twelve Days of Christmas"

On the twelfth day of Christmas, my true love gave to me ...

Twelve drummers drumming:

Y93.J2 Activity, drum and other percussion instrument playing

Eleven pipers piping:

Y93.J4 Activity, winds and brass instrument playing

Ten lords-a-leaping:

Y93.43 Activity, gymnastics

Nine ladies dancing:

Y93.41 Activity, dancing

Eight maids-a-milking:

Y93.K2 Activity, milking an animal

Seven swans-a-swimming

W61.91XA Bitten by other birds, initial encounter

Six geese-a-laying:

W61.59XA Other contact with goose, initial encounter

Five gold rings:

W49.04XA Ring or other jewelry causing external constriction, initial encounter

Full versions are available at:

www.aapc.com/christmas2012

"The Night Before Christmas"

'Twas the night before Christmas, when all through the house. Not a creature was stirring, not even a mouse.

W53.09XA Other contact with mouse, initial encounter

The stockings were hung by the chimney with care, in hopes that St. Nicholas soon would be there.

X06.2XXA Exposure to ignition of other clothing and apparel, initial encounter

The children were nestled all snug in their beds, while visions of sugar-plums danced in their heads.

Y93.84 Activity, sleeping

And mamma in her 'kerchief, and I in my cap, had just settled down for a long winter's nap.



W93.2XXA Prolonged exposure in deep freeze unit or refrigerator, initial encounter

When out on the lawn there arose such a clatter, I sprang from the bed to see what was the matter.

W42.9XXA Exposure to other noise, initial encounter

Away to the window I flew like a flash, tore open the shutters and threw up the sash.

W13.4XXA Fall from, out of or through window, initial encounter

The moon on the breast of the new-fallen snow, gave the lustre of mid-day to objects below.

X37.2XXA Blizzard (snow) (ice), initial encounter

When what to my wondering eyes should appear, but a miniature sleigh, and eight tiny reindeer.

R44.1 Visual hallucinations

With a little old driver, so lively and quick, I knew in a moment it must be St. Nick.

F22 Delusional disorders

Wishing you a wonderful holiday season,

A handwritten signature in dark ink that reads "Cynthia Stewart".

Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P

President, National Advisory Board



Surveillance Colonoscopy Rules Differ from Pure Screenings

I have information to add to **Sarah Sebikari's, MHA, CPC**, excellent review of how to code colonoscopies ("Consider All Factors when Coding Colonoscopies," October 2012, pages 26-28). There is another factor to consider that determines coverage for colonoscopies by some commercial insurance policies per the Affordable Care Act.

Although screening is defined in the article as "performed in the absence of symptoms," not all asymptomatic individuals having a colonoscopy are undergoing "screening;" some are undergoing a "surveillance" colonoscopy.

According to the United States Preventive Services Task Force (USPSTF), "When the screening test results in the diagnosis of clinically significant colorectal adenomas or cancer, the patient will be followed by a surveillance regimen and recommendations for screening are no longer applicable." Therefore, when a claim is received for a colonoscopy with one of the ICD-9-CM codes listed below, the colonoscopy may be considered "surveillance" rather than "screening."

V12.72 Personal history of colonic polyps

V10.05 Personal history of malignant neoplasm, large intestine

V10.06 Personal history of malignant neoplasm, rectum, rectosigmoid junction, and anus

The colonoscopy interval for screening in the USPSTF recommendation is every 10 years. Although not endorsing any specific interval for surveillance, the USPSTF recommendation specifies:

"In the models, the predicted total number of colonoscopies included those resulting from surveillance after detection of colorectal neoplasia. The models assumed lifetime monitoring by colonoscopy every 3 to 5 years depending on the number and size of the adenomas detected. It is not the intent of the USPSTF to endorse this particular approach to surveillance, but standardizing the approach to surveillance is necessary to compare screening strategies in the models."

The Affordable Care Act requires first dollar coverage only for *screening* colonoscopy; therefore, claims deemed to be "surveillance" may not be processed under the first dollar preventive care benefit.

Because of the potential financial impact to the patient, it is important that the colonoscopy be reported precisely. If a repeat colonoscopy is performed at an interval of less than 10 years due to previous findings of high risk, benign colonic polyps, you should use personal history of colonic polyps (V12.72) as the primary ICD-9-CM code and consider this a "surveillance" procedure not subject to first dollar reimbursement; however, if—despite the prior finding of polyps—the specialist still recommends the next colonoscopy 10 years in the future, consider this to be a screening colonoscopy and use V76.51 *Special screening for malignant neoplasm of colon* as the primary diagnosis.

Kenneth D. Beckman, MD, MBA, CPE, CPC

Author Sarah W. Sebikari, MHA, CPC, responds:

Surveillance colonoscopy would be considered a "follow-up" exam, as defined by ICD-9-CM follow-up code category V67. According to ICD-9-CM Official Guidelines for Coding and Reporting, §1ch18.d.8, "The follow-up codes are used to explain surveillance following completed treatment of a disease, condition, or injury... Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first followed by the history code." The ICD-9-CM guidelines further state, "Should a condition be found to have recurred on the follow-up visit, then the diagnosis code should be used in place of the follow-up code."

For example, in a patient with history of colon polyps undergoing follow-up colonoscopy with no additional findings, the appropriate diagnosis

per ICD-9-CM would be V67.9 Unspecified follow-up examination and V12.72. Some payers may not accept a nonspecific diagnosis code (e.g., V67.9) as primary; for these payers, list the high-risk diagnosis V12.72 first, as

Dr. Beckman suggests.

The American Gastroenterology Association considers surveillance colonoscopy a high-risk screening, while the American College of Gastroenterology equates a surveillance colonoscopy to a screening exam. Medicare does not use "surveillance" in context of a colonoscopy, defining patients as either at "low risk" or "high risk" for colon cancer.

When performing a colonoscopy in the absence of signs and symptoms for a Medicare patient, you would assign the screening V code as primary. If polyps are found and biopsied and/or removed, the colonoscopy is considered to be a diagnostic service (not a screening), but the screening V code would still be listed as primary, followed by the ICD-9-CM code that describes the specific findings (i.e., 211.3 Benign neoplasm of other parts of digestive system, colon). For complete instruction on billing Medicare for screening and/or diagnostic colonoscopy, see MLN Matters Number: SE0746 (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0746.pdf).

Documentation is crucial in accurate coding of colonoscopies. Physician practices should develop internal guidelines about how to report surveillance/follow-up colonoscopies, based on acceptable coding conventions and payer guidelines. Coding guidelines may be obtained from the American Medical Association (AMA) guidelines, the Centers for Medicare & Medicaid Services (CMS), the specialty associations, and individual payer guidelines.

As Dr. Beckman suggests, the first dollar preventive care benefit is easily misunderstood. And because colonoscopy billing creates plenty of room for patient dissatisfaction (especially in light of varying payer policies), physician and patient education is highly recommended.

Update: CPT® Appends Modifier 53 for Incomplete Colonoscopy

The article "Code an Incomplete Colonoscopy" (October 2012, page 28) advised, "The CPT® manual, in contrast to CMS rules, instructs, 'For an incomplete colonoscopy, with full preparation for a colonoscopy, use a colonoscopy code with the modifier 52 [Reduced services] and provide documentation.'" This information is outdated.

Medicare guidelines stipulate, "When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier of -53 [Reduced procedural service] to indicate that the procedure was interrupted," per CMS Program Memorandum Transmittal AB-03-114, change request 2822 (www.cms.hhs.gov/Transmittals/Downloads/AB03114.pdf).

CPT® guidelines are consistent with CMS policy. A "Coding Tip" preceding colonoscopy codes 45355-45392 instructs, "When performing an endoscopy on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope beyond the splenic flexure, due to unforeseen circumstances, report the colonoscopy code with modifier 53 and appropriate documentation."

CPT® 58661 Describes Hydrosalpinx Removal

The article "Slice and Dice Your Op Report" (October 2012) contained a typographical error on page 24. The correct code to report the second "slice" of the operative note example is not 58611, but 58661 *Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)*.

CPT® Changes 2013 and ICD-10-CM Workshops



"I was very impressed with the AMA's CPT Changes workshop. The presenter was very knowledgeable of all topics and stayed on task. It is one of my favorite seminars to attend, and I wouldn't miss it!"

— Roxanne Thames, CPC, CEMC

CEUs
available

Five locations

Baltimore, MD ■ Dec. 3–4
New Brunswick, NJ ■ Dec. 3–4
Irving, TX ■ Dec. 5–6
Las Vegas, NV ■ Dec. 10–11
Atlanta, GA ■ Dec. 13–14

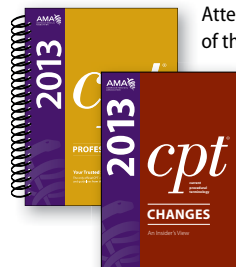
Attend one or both days

DAY 1

CPT® Changes 2013 Workshops

This straight-from-the source workshop educates on the process, rationale and application for the 568 code changes to the 2013 code set.

- Overview of CPT changes, including added, revised and deleted codes
- Rationales behind the 700+ code and guideline changes
- Learn about general changes references, modifiers and E/M codes



Attendees receive a free copy of the AMA's premier codebook *CPT® 2013 Professional* and *CPT® Changes 2013*

DAY 2

ICD-10-CM Workshops

Learn, implement and code in a one-day workshop where subject experts explain the details and how-to of ICD-10-CM coding.

- Case studies to help develop and practice coding skills
- Extensive review of guidelines and regulations
- Examine how documentation requirements affect performance



Attendees receive a free copy of the AMA bestseller *Principles of ICD-10-CM Coding*.

Learn more or register today by visiting ama-assn.org/go/CPTchangesworkshops or ama-assn.org/go/ICD10workshops.



End Your Chapter Year with Festive Fun

Add hands-on coding and seasonal melodies to your chapter meeting repertoire.

"Jingle Bells, Jingle Bells, Jingle all the way! Oh, what fun it is to ride in a one horse open sleigh" ... that is, until you develop acute bronchitis and a case of acute bronchopneumonia. When you go in to see your family doctor he codes the office visit as an evaluation and management (E/M) service for an established patient with expanded problem-focused history and exam, and low complexity medical decision-making (MDM). He also orders and reviews a two-view chest X-ray and a complete blood count with automated differential. Assign the CPT® and diagnoses codes for this visit.

And that's how to play a quick game of "Christmas Carol Coding," aka "Holiday Carol Coding" or "Code that Carol."

A Simple Coding Crowd Pleaser

For your holiday and year-end celebrations, think outside the box and put some fun into your local chapter with new games. For example, you might code scenarios for songs celebrating New Year's Eve, Christmas, Hanukkah, Kwanzaa, the winter season, etc.

My chapter has really enjoyed playing this game at annual holiday meetings. In addition to the hands-on coding practice this game offers, chapter officers plot different outcomes, giving everyone the giggles while working on both procedure and diagnosis coding. It's just another reason to love our profession!

You can craft the rules any way your chapter sees fit. Have individuals code the carols or break into teams for even more fun.

Include Any Holiday or Festive Hit

Get creative as you think of scenarios for

songs such as:

- **"I Saw Mommy Kissing Santa Claus"**... and she may have passed along a bad case of mononeucleosis she's been harboring. Santa isn't sick yet, but the doctor ran a screening test to find out for sure if he would make his normal holiday rounds. What codes would you use for the lab test and the diagnosis?

- **"Oh, dreidel, dreidel, dreidel!"** I made it out of clay. And when it's dry and ready, then dreidel I shall play." In our Hanukkah game excitement, the clay dreidel was spun so hard it landed on a foot and broke two metatarsals. Ouch!

Although no surgery was required, the patient was put into a cast while he healed. Code the fracture care and the diagnoses for two metatarsal fractures.

Members will get excited when there is something challenging AND fun to wrap their minds around. Networking is key at your holiday meeting as you sit next to someone and work on or compare answers together. You will be surprised at the variety of solutions you actually get for different scenarios.

Use the carol coding game as an opportunity to bring your next year's officers into the spotlight. Let them create and work on their own holiday coding scenario to see how well they work as a team.

Are You Up to the Challenge?

If the aforementioned coding carol scenarios seem easy to you, then try coding my personal favorite challenge: "Grandma Got Run Over By a Reindeer." Grandma ends up with more conditions than should be humanly possible! Here's the first verse:

"Grandma got run over by a reindeer, walking home from our house Christmas Eve, you can say there's no such thing as Santa, but as for me and Grandpa, we believe. She'd been drinking too much eggnog and we begged her not to go, but she'd left her medication, so she stumbled out the door into the snow."

Code all of the problems in this holiday fiasco, including Grandma's overindulgence in eggnog, her failure to follow medical instructions by skipping her medicine, and that she was struck by a non-motorized vehicle being pulled by an animal.

Let the Games Begin

We won't provide you with all of the answers to these festive scenarios, but we will help you with the "Jingle Bells" doctor's visit. The CPT® and ICD-9-CM coding should be:

- 99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 or these 3 key components; An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity.
- 71020** Radiologic examination, chest, 2 views, frontal and lateral
- 85025** Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
- 466.0** Acute bronchitis
- 485** Bronchopneumonia, organism unspecified

Figuring out the rest of the coding scenarios is up to you, so aim high. Enjoy your holiday chapter meetings, and make it a great new year for your 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 Barbara Fontaine, CPC

Hardship Scholarship Ignites Member Generosity

The AAPC Chapter Association (AAPCCA) Hardship Scholarship Fund has spread like wildfire. Since its inception in April 2012, the committee has reviewed many applications from members who need a little help to keep their certification in times of financial stress. With an approved application members are able to pay for annual AAPC dues, attend continuing education unit (CEU) presentations, and buy coding books to maintain certification requirements.

To keep this project on target, participation from everyone is necessary. With only a \$1 donation from every member, the AAPCCA could help many more coders in need. The applications we have received for assistance greatly outnumber what the current balance in the fund allows. Chapters from all over the United States are stepping up to help. If your chapter hasn't yet, we ask you to encourage your members to join us.

Donate Extra Year-end Cash

It's nearing the end of the year and financial reports are due to the national office soon. Take a look at your chapter's bottom line, and if you find a little extra money in your bank account, consider donating to the scholarship fund to help fellow coders in need. A little money from everyone goes a long way when we all work together.

Other Ways to Raise Money

Many local chapters have shared ideas to help raise money for this important cause:

- Have a raffle using donated prizes or a 50/50 share, with the proceeds going to the scholarship fund.
- Put a collection jar at the registration table of your meeting or conference.
- Hold a contest to see who can come up with the most creative fundraising idea, and then have your members follow through with it.
- Donate to the scholarship fund instead of exchanging holiday gifts.
- Honor a president as he or she leaves office with a donation from your chapter.
- Mention the scholarship fund in your newsletter and ask your members to bring a donation to your next meeting.



An Amazing Experience

One dollar per member would go a long way to help a fellow member. You never know who may need your help in times of financial uncertainty. If your chapter can afford to offer more, please do it.

Let's help AAPC and our membership to do as much good as possible, wherever possible, for as long as possible. Keep the Hardship Scholarship Fund a priority in your chapters.

Scrub Away Unclean Claims & Work Faster CMS-1500 Scrubber from SuperCoder

Featuring additional coding logic, it's like having a coding and billing analyst on your side!

Spend less time coding and billing and find your errors as you go with **CMS-1500 Real-Time Scrubber**. Cut work time with quick-start feature that identifies allowed code and modifiers as you type.

This claims scrubber prevents denials with:

- Optional demographic entries to take you straight to code combo checking
- CPT® concept checking that goes further than CCI to divulge combos which are not allowed according to AMA
- Physician Fee Schedule code status errors alert you to non-billable Medicare combinations
- Modifier crosswalk lets you check the right use of modifier 24, 25, 59 and more
- Medical necessity verification against LCD, NCD, and ICD-9 CrossRef featuring private payer top reported diagnoses

Submit cleaner claims and expedite payments!

Subscribe Now!

 SuperCoder.com

To order visit us online www.SuperCoder.com/scrubber/cms1500/ or call us at 1-866-228-9252 and mention code AO2IS011.

The Coding Institute LLC
2222 Sedwick Drive, Durham, NC 27713

Follow Splints, Casts, and IOL Payment Instructions in 2013

Medicare payment continues in 2013 for splints, casts, and intraocular lenses implanted in a physician's office. Effective Jan. 1, 2013, the Centers for Medicare & Medicaid Services (CMS) instructs:

For splints and casts, HCPCS Level II Q codes should be used when supplies are indicated for cast and splint purposes. This payment is in addition to the physician fee schedule procedure payment for applying the splint or cast.

For intraocular lenses (IOL), payment is only made on a reasonable charge basis for lenses implanted in a physician's office (HCPCS Level II codes V2630 *Anterior chamber intraocular lens*, V2631 *Iris supported intraocular lens*, and V2632 *Posterior chamber intraocular lens*).

The 2013 payment limits for splints and casts are based on the 2012 limits announced in last year's change request (CR) 7628, increased by 1.7 percent. Splints and casts furnished in 2013 will be paid based on the lower of the actual charge or the payment limits established for these codes.

For 2013 payment limits for splints and casts, see *MLN Matters* 7628 and CR 8051 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2565CP.pdf).

Avoid E Codes as First Dx, or Face Claims Rejection

When submitting claims to Medicare, be certain you don't list an ICD-9-CM E code as the first diagnosis, or your claims will be returned to you. E codes describe external causes of injury or poisoning. ICD-9-CM prohibits E codes from being reported as principal diagnoses.

Effective Jan. 1, 2013, CMS transmittal 2515 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2515CP.pdf) instructs contractors to return claims submitted on Form CMS-1500 when an ICD-9-CM E code is reported as the first diagnosis of the claim in Item 21. This instruction will bring the policy for handling Form CMS-1500 paper claims into alignment with the policy for handling claims initially submitted in electronic format. The new edit will also apply to ICD-10-CM codes V00-Y99 when they become effective Oct. 1, 2014.

Refer to *MLN Matters*® MM7700 (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7700.pdf) for handling CMS claims reported with an E code as the first diagnosis code in Item 21.

A&P Quiz



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

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

Raynaud's disease is a condition that causes one or more areas of the body—typically fingers, toes, the nose, and ears—to feel numb and painfully cold in response to cold temperatures or stress. The smaller arteries supplying blood to the skin constrict, preventing adequate blood circulation to the affected areas.

Raynaud's is fairly easy to diagnose because the signs and symptoms are generally the same for everyone and are external as much as they are internal. During an attack, symptoms may include:

- Abnormally cold appendages
- Skin color changes in affected areas
- Numbness and pain in affected areas

During an attack of Raynaud's, the affected areas of skin usually turn white and then blue. These areas may feel cold and numb,

and lose some feeling. A person with Raynaud's suffering from an attack may also shiver uncontrollably. Upon warming, the affected body areas may turn red, throb, burn, tingle, and/or swell. The length of time an attack lasts depends on the severity of the condition, and how long the body was exposed to excessive cold or stress.

The cause of Raynaud's isn't completely known, but blood vessels in the hands and feet appear to overreact to cold temperatures or stress; and women are more likely to contract this disease than men. For people with Raynaud's, something as simple as putting their hands under a faucet of running cold water, taking something out of the freezer, or exposure to cold air can cause an attack. For some people, emotional stress alone can cause an episode.

There are two types of Raynaud's: prima-

ry (without an underlying disease) and secondary (with underlying disease). Some of the causes of secondary Raynaud's are scleroderma, lupus, rheumatoid arthritis, Sjögren's syndrome, diseases of the arteries, carpal tunnel syndrome, injuries, smoking, and certain medications.

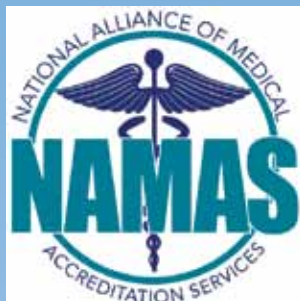
Where do your anatomy and physiology (A&P) skills rank? Test yourself:

If an artery was to become blocked, diminishing blood supply to an area affected by Raynaud's, what might occur?

- a. Skin ulcers
- b. Nerve damage
- c. Gangrene
- d. Both a and c

The answer is on page 49.

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



**NAMAS is extending our 2012 pricing for the
2013 CPMA[®] classes.**

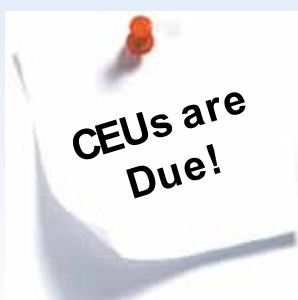
**Plus register for a class in 2013 before December 31, 2012
and we will take an additional \$100 off!**

Use code AAPC2012

**Don't forget about the *LAST CHANCE* to register for our
Auditors Career Kit!**

Attend a NAMAS Training session in 2012 and you will be registered for
the kit which will include:

- ★ 2013 CPT[®]/ICD-9/HCPSCS books
- ★ 2013 Coding Updates Book
- ★ NAMAS and AAPC paid memberships for 2013
- ★ Paid Admission to the NAMAS 5th Annual Auditing Conference
- ★ Paid Admission to the 2013 AAPC Annual Conference



NEED CPMA[®] CEUs?

NAMAS Members receive theirs for free!

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



Learn Why and How to Apply the Multiple Endoscopy Rule

Reporting rules vary depending on whether procedures are kept in the family or have no relation.

Takeaways:

- The multiple procedure rule reduces Medicare payment by 50 percent for the second and subsequent procedures provided to a single patient by the same physician on the same day.
- Find the “parent code” of each endoscopy procedure in CPT® or, more easily, in the MPFS.
- Unrelated codes performed on the same day by the same physician may be reported separately without payment reduction.

You’ve probably heard of the “multiple procedure rule,” which reduces Medicare payment by 50 percent for the second and subsequent procedures provided to a single patient by the same physician on the same day. But did you know that a modified version of the multiple procedure rule may apply when reporting two or more endoscopic procedures?

All in the Family

CPT® and the Centers for Medicare & Medicaid Services (CMS) classify endoscopic procedure codes by “family,” where each family is comprised of related services. Each family has a “parent” code—called the endoscopic base code—representing the most basic version of that endoscopic service.

Usually, the base code is the first-listed code within a sequence of codes in CPT®. For example, consider this partial code family:

- 45300** Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 45303** with dilation (eg, balloon, guide wire, bougie)
- 45305** with biopsy, single or multiple
- 45307** with removal of foreign body

In this case, 45300 describes the most basic version of the service. Codes 45303, 45305, 45307, etc., include the work of 45300, plus any additional work in the code descriptor.

A no fail way to find the endoscopic base code within each family is to consult the most recent Medicare Physician Fee Schedule (MPFS) Relative Value File. This file is updated at least annually (and often several times per year), and can be downloaded

from the CMS website at www.cms.gov/apps/physician-fee-schedule/documentation.aspx.

The column labeled “ENDO BASE” will tell you the parent code for every endoscopic procedure. If there is no code in the “ENDO BASE” column, the code in column “A” is the base code (or the code in column “A” is not an endoscopic procedure). You can confirm the multiple-scope rule applies to a given code if you find a “3” in the “MULT PROC” column.

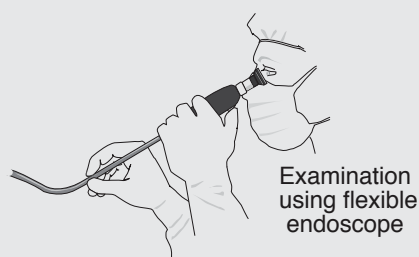
Apply Multiple Scope Rule

At its most basic, the multiple scope rule requires you to always bundle diagnostic endoscopy with any surgical endoscopy within the same family. For example, if a surgeon performs diagnostic sigmoidoscopy (45330 *Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*) followed by sigmoidoscopy with control of bleeding (45334 *Sigmoidoscopy, flexible; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)*), you may report only 45334 because the endoscopic control of bleeding includes the work of a diagnostic endoscopy, 45330.

When a physician performs two endoscopic procedures in the same family, and neither procedure represents the base procedure, you may report both codes. Medicare payers will reimburse the most extensive (i.e., highest-valued) endoscopy at full value, and will reimburse any additional endoscopies in the same family by subtracting the value of the base endoscopy and paying the difference.

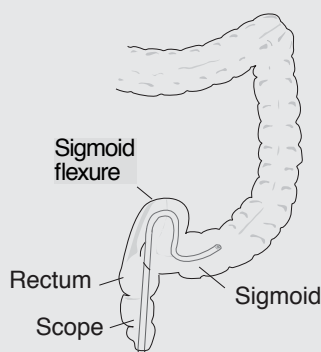
As an example, a surgeon performs sigmoidoscopy with tumor removal by hot forceps

When a physician performs two endoscopic procedures in the same family, and neither procedure represents the base procedure, you may report both codes.

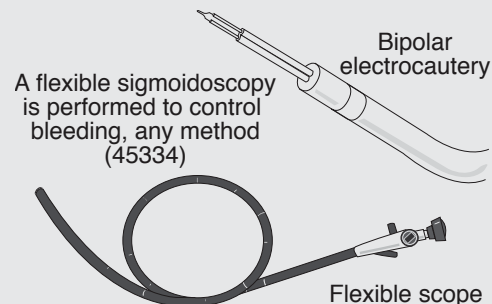


Report 45330 for a diagnostic exam that may or may not include collection of specimen(s) by brushing or washing. Report 45331 when biopsy tissue is collected, single or multiple

Anatomical Illustrations © 2012, Optuminsight, Inc.



Any of a variety of methods such as bipolar cautery are used via a flexible scope to control bleeding in the lower colon



(45333 *Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery*), followed by medically-necessary removal of polyps by snare technique (45338 *Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*). Because neither endoscope is the base procedure, you may report both procedures. Medicare will reimburse the more extensive procedure (45338, with 9.66 fully implemented non-facility relative value units (RVUs)) at full value. Medicare will also pay the value of the second scope, minus the value of the base procedure. In this case, the secondary scope, 45333, has 9.0 RVUs, from which we must subtract the 4.23 RVUs assigned to the endoscopic base code 45330.

No Relation = No Multiple Scope Deduction

The multiple endoscopy rule applies only when the physician performs two or more

endoscopies in the same family. You don't need to worry about the rule if the physician performs multiple endoscopies from different code families. For example, if a surgeon performs flexible sigmoidoscopy with single biopsy (45331 *Sigmoidoscopy, flexible; with biopsy, single or multiple*) and esophagoscopy with biopsy (43202 *Esophagoscopy, rigid or flexible; with biopsy, single or multiple*) during the same session, you may report each separately without payment reduction because these scopes are not part of the same code family (the base code for 45331 is 45330, while the base code for 43202 is 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)*). ¹⁴

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

Successfully Report ERCP and Related Procedures

Keep abreast on treatments and CPT® guidelines to eliminate coding assignment insecurities.

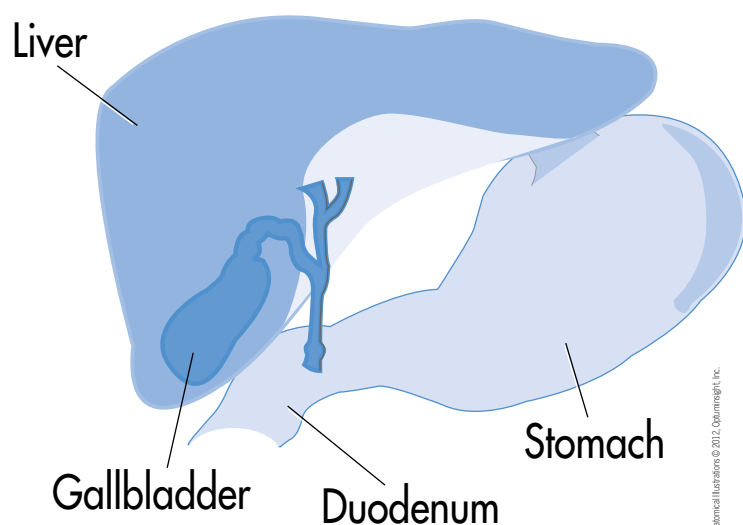
Endoscopic retrograde cholangiopancreatography (ERCP) is much easier to report than it is to say; but let your guard down and you might slip up when assigning CPT® codes for ERCP-related procedures. Up-to-date coding information on biliary and pancreatic duct stenting procedures, such as that found in the American Medical Association (AMA) article, “THEN and NOW Endoscopic Retrograde Cholangiopancreatography” (*CPT® Assistant*, January 2012, volume 22, issue 1, page 11), will help you from getting tongue-tied when these types of procedures cross your desk.

Get to Know ERCP

An ERCP is a study of the ducts that drain the liver and pancreas. Indications for this procedure include biliary obstruction due to cholelithiasis or strictures, sphincter of Oddi dysfunction, acute and chronic pancreatitis, pancreatic pseudocysts, pancreatic necrosis, and pancreatic duct strictures.

To assign CPT® codes accurately, first be familiar with the anatomy involved, including that of the stomach, duodenum, liver, gallbladder, pancreas, biliary and pancreatic ducts, and the ampulla of Vater.

The liver produces bile, which helps the small intestine digest food. The bile is collected by a system of ducts that flow from the liv-



Takeaways:

- An ERCP is a study of the ducts that drain the liver and pancreas.
- Several procedures are performed via the esophagus through the duodenoscope.
- CPT® includes two codes for reporting ERCP with stenting procedures.

er through the right and left hepatic ducts and drain into the common hepatic duct. The common hepatic duct joins with the cystic duct from the gallbladder to form the common bile duct (CBD). The CBD drains bile into the intestine through the ampulla of Vater. Not all bile runs directly into the duodenum; approximately 50 percent of bile produced by the liver is first stored in the gallbladder and released when needed.

The pancreas is an elongated, tapered organ located across the back of the abdomen behind the stomach. This organ contains exocrine glands, which secrete digestive enzymes. These enzymes are secreted into a network of ducts that join the main pancreatic duct, which runs the length of the pancreas. The pancreatic duct, also known as the duct of Wirsung, then joins the common bile duct just prior to the ampulla of Vater and allows secretion of the pancreatic enzymes into the duodenum.

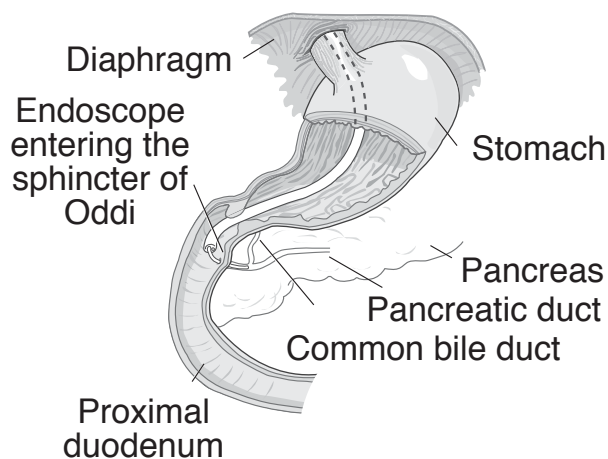
In a diagnostic ERCP, the patient is typically sedated with intravenous sedation and analgesia. The doctor inserts the duodenoscope down the esophagus, through the stomach, and into the duodenum. Air is usually pumped through the endoscope to inflate the stomach and duodenum to make the examination easier. The duodenal papilla is located and catheterized, followed by an injection of dye into either the biliary or pancreatic duct (or both). Imaging of the ducts allows the physician to look for narrowed areas or blockages and determine necessary treatment.

Procedures performed through the duodenoscope include biopsy; sphincterotomy; destruction or removal of calculus; insertion, change, or removal of stents; dilation of the ducts; and ablation of lesions. CPT® includes codes for all of these procedures. The *CPT® Assistant* referenced in this article specifically addresses coding for stenting procedures.



As always, clear and accurate physician documentation is the key to accurate code assignment and appropriate reimbursement.

Anatomical Illustration © 2012, Outmanight, Inc.



Assign Codes with Accuracy

CPT® includes two codes to report ERCP with stenting procedures: 43268 *Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct* and 43269 *Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent*.

Updated instructions direct that when a stent is placed in both the common bile duct and the pancreatic duct, 43268 may be reported twice, with modifier 59 *Distinct procedural service* appended to the second code. This tells the payer the additional stent was placed at a different site.

CPT® Assistant specifies that when a stent is placed in the common bile duct extending into the right hepatic duct, and another stent is placed in the common bile duct extending into the left hepatic duct, it is again permissible to report 43268 twice with modifier 59 appended. Physician documentation should include information regarding the location of the proximal end of the stent.

Conversely, if multiple stents are placed in one duct (either side-by-side or overlapping), 43268 may be reported only once.

For the endoscopic removal and replacement of ductal stents, the guidelines are the same. Code 43269 would be reported twice if multiple stents in separate ducts are both removed and replaced during the same operative session. Only one code would be reported for removal of two stents in the same duct.

CPT® Assistant directs that when two stents are removed and only one stent is replaced, 43269 would be reported only once. As always, clear and accurate physician documentation is the key to accurate code assignment and appropriate reimbursement. ■

Clinical Scenario: A 65-year-old woman presents with abdominal pain, poor appetite, and jaundice. A CT scan of the abdomen shows a dilated intrahepatic biliary tree and a collapsed gallbladder. A Klatskin tumor is suspected. ERCP is scheduled and performed.

After informed consent and appropriate sedation, the duodenoscope was inserted into the oropharynx, down the esophagus, and into the stomach. The scope was then advanced through the pylorus to the ampulla. Cannulation of the ampulla was performed and contrast injected through the catheter into the biliary duct.

Imaging revealed filling defects of the right and left hepatic ducts. The biopsy forceps were then passed through the working channel of the duodenoscope and biopsies of the hepatic ducts were obtained. A stent was placed into the right hepatic duct followed by a separate stent placed into the left hepatic duct to improve drainage.

The stomach was then decompressed and the endoscope withdrawn. Pathology results confirm diagnosis of Klatskin tumor.

Coding:

ICD-9-CM:

156.1 Malignant neoplasm of extrahepatic bile duct

CPT®:

- 43261** Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple
- 43268** ERCP with retrograde insertion of tube or stent into bile or pancreatic duct [right duct]
- 43268-59** ERCP with retrograde insertion of tube or stent into bile or pancreatic duct [left duct]
- 74328** Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation



Laurette Pitman, RN, CPC-H, CGIC, CCS, is a senior outpatient consultant for Spi Healthcare. She has over 30 years' experience in the health care field including ED and OR nursing, coding, and DRG and APC auditing. For more information, please reference www.spihealthcare.com or contact her at laurette.pitman@spihealthcare.com.

Hospital Coding: It Isn't Just for Inpatients

Facility outpatient coding differs in significant ways from provider coding.

A common misconception is that hospital coding is synonymous with inpatient coding, but hospitals provide many services in addition to inpatient care. Hospital coders may find themselves coding for different settings, such as the facility's outpatient clinics, emergency department (ED), urgent care center, ambulatory surgery center (ASC), laboratory, observation unit, diagnostic radiology, and other departments.

To give you an inkling of what's required of a hospital coder, we'll focus on several aspects of hospital outpatient coding and assignment of evaluation and management (E/M) codes in the hospital/facility setting. We'll also introduce you to Medicare's Outpatient Prospective Payment System (OPPS) and the charge description master.

Facility Bill Includes All But the Doc

Outpatient coding captures facility expenses. All things must be recouped in the facility's reimbursement, including the cost of the operating room, the nursing staff, the medical supplies, all salaries, all utilities, and building maintenance. The physician's service fee, however, is not usually part of this bill.

E/M Code Assignment

When most coders think of E/M coding, they think of the Centers for Medicare & Medicaid Services' (CMS) 1995 and 1997 *Documentation Guidelines for Evaluation and Management Services*. These systems are point based and rely heavily on the documentation level in the three key components of history, examination, and medical deci-

Takeaways:

- Outpatient coding is common in facilities and found in many settings, but it differs from provider coding.
- Facility E/M coding doesn't rely on the 1995 or 1997 documentation guidelines.
- Much facility coding is based on APCs, which take into account the resources used by the facility when providing the service.
- Most facilities have chargemasters, on which outpatient fees are based.

sion-making. These are national guidelines used in physician E/M coding.

Hospitals do not follow the 1995 or 1997 documentation guidelines for reporting their facility services; national facility E/M coding guidelines do not exist. There is, however, a set of standards, and each facility is responsible for developing and using its own internal E/M code assignment guidelines. These guidelines are based on the intensity of the service(s) documented and provided. However, coders must be careful because the level of E/M assigned for professional services will not always match the facility E/M level.

The American College of Emergency Physicians (ACEP) offers an easy method for assigning E/M levels for EDs, basing levels on possible interventions and including potential symptoms/examples to support those interventions. An article and corresponding E/M guide can be found on ACEP's website (www.acep.org).

In the E/M grid provided on the ACEP website, levels are building blocks: The higher E/M levels could include interventions from the lower levels. For example, let's take a look at the options for patients treated for trauma. According to ACEP's E/M grid:

- A patient seen for a simple trauma

with no X-rays is reported with 99282 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity.*

- A patient seen for a minor trauma (with potential complicating factors) is reported with 99283 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity.*
- A patient treated for blunt/penetrating trauma with limited diagnostic testing is reported with 99284 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity.*
- A patient with blunt/penetrating trauma requiring multiple diagnostic tests is reported with 99285 *Emergency department visit for the evaluation*



The level of E/M assigned for professional services will not always match the facility E/M level.

and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.

As the possible interventions and potential symptoms increase, so does the reportable E/M level.

Medicare's Hospital OPPTS

The OPPTS was developed in 2000 to reimburse certain services in the outpatient setting. Often, the payment is made in the Ambulatory Payment Classification (APC). Although not all services are paid through the APC, the calculation of the reimbursement is based on a package of services. The services included in the APC are not individually paid.

For example, for 2012, CMS proposed APC 8009 *Cardiac resynchronization therapy with defibrillator composite*, which combined payment for CPT® codes 33225 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system and pocket revision)* (List separately in addition to code for primary procedure) and 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber*.

This does *not* mean, however, that all outpatient services provided on the same date of service are included in the APC.

Find more information about OPPTS on the

CMS website:

- www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctst.pdf
- www.cms.gov/HospitalOutpatientPPS/05_OPPSGuidance.asp#TopOfPage

Charge Description Master

The APC is based on a HCPCS Level I (CPT®) or Level II code and medical necessity, often determined by the associated ICD-9-CM codes. Many hospitals have a financial system that will assign the HCPCS code using a charge description master (CDM). The CDM is often invisible to the person assigning the financial code and to the coder. The financial code may be a general ledger code, an inventory code, or other description. Using a dictionary or decision tree, the facility computer system will look at the general ledger code and the patient insurance information to assign the HCPCS code and revenue codes (used to summarize all services within a department on the bill).

Coders' Involvement


Before final processing, the coding department should look at the charges, assign the diagnosis codes, and ensure the services are medically appropriate (i.e., confirm medical necessity). The billing department may also look at the bill prior to submission to verify insurance coverage. Using the encoders, insurance company edit tools, and National Correct Coding Initiative (NCCI) edits, both departments may verify that all charges are included to ensure prompt, accurate payment.

Health insurance management (HIM) and billing departments often have predefined

computer parameters to review services. For example, the date requirement may be "any account five days post discharge," and a minimum dollar amount, such as "any account over \$100." Each coder may have a predefined set of work parameters, or work lists, to review. For example:

- Coder Amy may look at all Medicaid pediatric accounts.
- Coder Betty may look at all Medicaid adult accounts.
- Coder Carol reviews all Medicare with a last name range of A-L.

This process allows coders to more easily conduct a review of charges compared to the medical record to detect any additional or missing charges, and also verify assignment of all diagnoses. For example, if there are magnetic resonance imaging (MRI) results, but no charge, the bill may be placed on hold.

The outpatient bill should reflect the actual services rendered, leading to proper reimbursement. The assignment of accurate and compliant codes allows facilities to be properly reimbursed for the quality care they provide. 



Catrena Smith, CPC, CCS, CCS-P, is owner of Access Quality Coding and Consulting, LLC in Orange Park, Fla. Access Quality Coding and Consulting provides coding education and training, auditing, coding, and account management services in hospital and physician settings.

Elizabeth Giustina, CCS-P, has worked in many settings, including the Military Health System, inpatient and outpatient hospitals, and physicians' offices. She works for First Class Solution as a consultant for ICD-10 documentation improvement, and also does CPT® auditing and coding.

Get Ready: The **RACs** are Coming!

Be prepared and keep a watchful eye on the automated issues RACs are reviewing for outpatient services.

Takeaways:

- Know what RACs are looking for.
- Conduct internal audits to resolve issues before RACs come knocking.
- Don't be afraid to appeal a determination with which you disagree.

Preparing for, and responding to, recovery audit contractor (RAC) reviews can be intimidating. You can lessen the pain, however, by understanding Medicare billing and coding rules and requirements, and being proactive in implementing controls to ensure compliance.

RACs Review Across the Nation

Section 302 of the Tax Relief and Health Care Act of 2006 made the Recovery Audit Program permanent, and required that it be expanded to all 50 states by 2010. The Recovery Audit Program's mission is to reduce Medicare improper payments by detecting and recovering overpayments, identifying underpayments, and developing methods to prevent future improper payments. There are four RACs, each serving a specific region in the country (see next page for the regional split).

RACs review claims on a post-payment basis following Medicare policies. RACs are required to employ a staff consisting of nurses, therapists, certified coders, and a physician medical director. There are two types of reviews: automated and complex. Complex reviews require a medical record to complete the review. According to the Statement of Work for the Recovery Audit Program, "The Recovery Auditor shall not attempt to identify any overpayment or underpayment more than three years past the date of the initial determination made on the claim. The initial determination date is defined as the claim paid date."

What to Watch

Each RAC publishes a list of improper coding issues approved by the Centers for Medicare & Medicaid Services (CMS) on its website. Each issue indicates which type of provider(s) is subject to review. Many of the inpatient issues relate to medical necessity for certain diagnostic-related groups (DRGs) and are considered to be "complex" reviews. For outpatient facility services and physician practices, many of the approved issues are automated. These issues test for Medicare billing and coding guideline compliance, which CMS publishes on its website.



Keep in mind that RAC reviewers are not necessarily certified coders. Moreover, they are human, and they make mistakes.

Some examples of approved issues include:

- Once-in-a-lifetime procedures (e.g., “welcome to Medicare” exam)
- Medically-unlikely edits (expected units per encounter)
- Add-on codes without a primary code
- National Correct Coding Initiative (NCCI) column 1/column 2 edits
- Procedures with no corresponding device code
- Minor surgery and other treatments billed as an inpatient stay
- Outpatient services within 72 hours of admission
- Exact duplicate outpatient claims
- Outpatient claims billed within a prospective payment system (PPS) inpatient admission
- Skilled nursing facility (SNF) consolidated billing

Prepare to Prevail

Don't wait for a RAC to knock on your door. Be proactive and follow these RAC review preparatory tips:

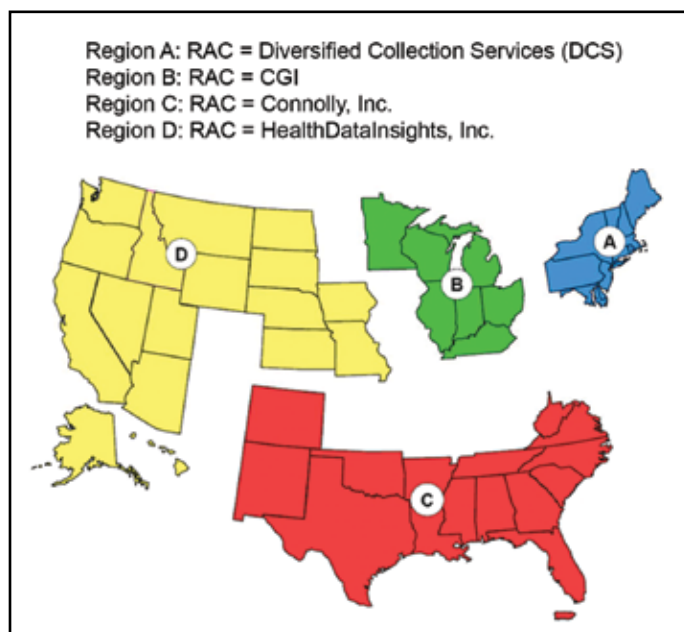
Research improper payments found by RACs, the Office of Inspector General (OIG), and comprehensive error rate testing (CERT).

- Review the RAC-approved issues on each contractor's website.
- Peruse the OIG and CERT audit reports online.

Conduct an internal assessment to identify if you are in compliance with Medicare rules. For example:

- Take one RAC-approved issue per week and do your own random audit of claims to identify questionable areas of compliance.
- Use existing quality assurance/audit professionals to incorporate RAC-approved issues into your routine audit process.
- Review existing bill scrubber edits/rules to ensure edits are in place to capture claims with specific codes (or code pairs). For example, there should be a pre-billing edit to catch claims that have an implant procedure code, but no implantable device code.

Current RAC Contractors



Identify corrective actions to promote compliance.

- Educate charge entry (or coding) staff when trends of non-compliance are noted.
- Implement a quality assurance process (either human or automated) to review complex claims prior to claims release.
- Be sure to maintain the most updated provider manuals and CMS regulations, and disseminate the information to all appropriate parties.
- Review the RAC-approved issues periodically for changes.
- If issues are found, work with the billing office to determine whether it is appropriate to re-bill the noncompliant claims.

Prepare to respond quickly to RAC requests.

- Understand who receives RAC request letters and ensure he or she is educated about the importance of a timely response.
- Have a process in place to release records as requested within the appropriate time frame.
- Be sure whoever is releasing the information understands the components of the legal medical record and where to find all required information.

Appeal when necessary (within 120 days).

- There are specific steps to take when appealing decisions outlined in detail on the CMS and RAC websites.

Get More Info on RACs

- **CMS website:** www.cms.gov/Recovery-Audit-Program/Downloads/MLNMattersArticle.pdf
- **RAC website:** www.cms.hhs.gov/RAC
- **RAC email:** RAC@cms.hhs.gov
- **Statement of RAC work:** www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf
- **Region A:** DCS (www.dcsrac.com)
- **Region B:** CGI (www.racb.cgi.com)
- **Region C:** Connolly (www.connolly.com)
- **Region D:** HealthDataInsights (www.healthdatainsights.com/rac)
- **OIG reports:** www.oig.hhs.gov/reports.html
- **CERT reports:** www.cms.hhs.gov/cert

- Appeal when you disagree with the decision; appeals must be completed in a timely manner.

Learn from past experiences; track denials and look for patterns.

- When a RAC repayment is made, correct the problem going forward. Educate the offending department(s) to ensure they understand how to charge and code correctly. If you have multiple facilities, share knowledge across all facilities.
- Work with your billing office to identify trends of billing

denials prior to RAC reviews; follow the same mitigation steps to avoid future RAC findings.

- Review pre-billing edits to identify patterns of misuse and educate the departments accordingly.

Don't Be Afraid to Appeal

Do not wait for RACs to request records or data before conducting these internal assessments. Keep in mind that RAC reviewers are not necessarily certified coders. Moreover, they are human, and they make mistakes. If you feel repayment is requested in error, appeal the decision. It is well worth the expended resources when you win an appeal.

Remember to be proactive—don't wait for a RAC to appear. If one has not already visited you, it is only a matter of time. No provider is exempt from RAC review. Conduct internal assessments based on the published, approved issues. If your claims are submitted in compliance with Medicare regulations, you should not encounter any serious issues with a RAC. ■



Amy Lee Smith, MBA, CPC, CPC-H, CPMA, CIA, CRMA, is manager of internal audit at Bon Secours Health System, Inc., where she primarily performs coding and billing audits. She earned her bachelor's and master's degrees in business administration with a concentration in finance from The College of William and Mary in Virginia. Ms. Smith is also a Certified Internal Auditor and certified in risk management assurance.



Our CD-ROM/CEU course line-up:

- (Stay tuned to our website for a new **ICD-10** topic)
- E/M from A to Z (18 CEUs)
 - Primary Care Primer (18 CEUs)
 - E/M Chart Auditing & Coding (16 CEUs)
 - Demystifying the Modifiers (16 CEUs)
 - Medical Coding Strategies (15 CEUs)
 - Walking Through the ASC Codes (15 CEUs)
 - Elements of ED Coding (11 CEUs)

HealthcareBusinessOffice LLC: Toll free **800-515-3235**
Email: info@HealthcareBusinessOffice.com

Web site: www.HealthcareBusinessOffice.com

Holidays at home and earn CEUs!

Need CEUs to renew your CPC®? Stay in town. At home. Use our CD-ROM courses anywhere, any time, any place. You won't have to travel, and you can even work at home.

- From the leading provider of interactive CD-ROM courses with preapproved CEUs
- Finish at your own speed, quickly or leisurely
- Just 1 course earns as much as 18.0 CEUs
- Use any Windows® PC: home, office, laptop
- No annoying timeouts. No expiring passwords.

Finish a CD in a couple of sittings, or take it a chapter a day — you choose. So visit our Web site to learn more about CEUs, the convenient way!

(Some courses also have CEU approval from **AHIMA**. See our Web site.)

Easily affordable with **EasyPayments!**
www.HealthcareBusinessOffice.com/easypay.htm



Follow us on Twitter:
twitter.com/hbolic



Continuing education. Any time. Any place.™



Tackle the transition one step at a time. **Optum can help.**

Take steps to prepare for ICD-10. No matter where you are in the process, we have solutions that can help ease the transition.

Step 1: Familiarize

Become familiar with the code sets by reviewing the drafts and then evaluate training materials and software.



Step 2: Analyze and improve processes

Conduct impact analysis on revenue and documentation improvement to understand where the gaps are between ICD-9 and ICD-10.



Step 3: Train

Begin training and developing sound coding practices for ICD-10.



**Experience the full power of Optum ICD-10 resources.
Start shopping today and save up to 20%.***

 **Save 20%.** Visit www.optumcoding.com to order online.

 **Save 15%.** Call 800.464.3649, option 1.

Use promo code **157881** to receive your discounts.

Purchase our hottest seller for \$30 off: the 2013 ICD-10-CM Clinical Documentation Improvement Desk Reference

*Discounts do not apply to eSolutions

12-29022 12120064 12/12 © 2012 Optum. All rights reserved.

INGENIX®

Ingenix is now Optum
— a leading health services business.

By Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC
and G.J. Verhovshek, MA, CPC

CPT® 2013 Preview:

Find Your Way in a Changing Landscape

Pull out your new CPT® codebook and plot your course.

The practice of medicine constantly evolves. Established roads change direction. Familiar landmarks disappear, and new paths emerge. Even those who know the lay of the land can feel lost in an ever-shifting terrain of technologies, methods, and standards of care.

To keep your bearing, your maps must be accurate and up-to-date. For 2013, CPT® supplies a host of new directions, including more than 650 code changes, new and revised section guidelines and parenthetical instructions, and much more. Here's a preview of what you can expect.

E/M Services

Eighty-two evaluation and management (E/M) codes in the range 99201-99467 are revised to allow a physician or other qualified health care professional to provide services. The revisions clarify that each state's scope-of-practice laws (*not* CPT® descriptor language) determine the services an individual provider is qualified to perform.



The two changes in the Anesthesia chapter are part of a recurring theme for 2013; revised descriptors no longer limit reporting to physicians.

For example, the revised descriptor for a level I, new outpatient visit (99201) specifies:

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

A problem focused history;

A problem focused examination;

Straightforward medical decision making.

Counseling and/or coordination of care with other physicians, other providers qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend Typically, 10 minutes are spent face-to-face with the patient and/or family.

New (underlined) text allows that counseling and/or coordination of care may be provided with other physicians *or* “other qualified health care professionals,” and deleted (strikethrough) text eliminates the reference to “physician” time. Coding requirements are otherwise unchanged.

Descriptor changes throughout the E/M chapter are consistent with this example; where code descriptors are unchanged, section guidelines have been modified to allow non-physician providers (NPPs) to report services. For example, the descriptors for critical care services (99291-99292, 99468-99469, and 99471-99476) are unchanged, but section guidelines now stipulate “Critical care is the direct delivery by a physician(s) *or other qualified health care professional* of medical care for a critically ill or critically injured patient.”

CPT® 2013 also adds three new categories of E/M services, for a total of seven new E/M codes:

Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient (99485-99486): These time-based codes report the non-face-to-face work performed by the control physician (the provider directing care) during an interfacility transport. The patient's age, medical condition (critical illness or critical injury), and the total time must be documented.

Complex chronic care coordination services (99487-99489): These time-based services are provided to patients with complex chronic illness(es) residing at home or in a domiciliary, rest home, or assisted living facility, and typically involve implementing a care

Takeaways:

- 2013 brings more changes to CPT® than we've seen in years.
- Hundreds of codes and guidelines have been broadened to include “other qualified health professionals.”
- Look for new codes in the Evaluation and Management, Surgery, Pathology and Laboratory, and Medicine sections of CPT®.

plan directed by a physician or other qualified health care professional.

Transitional care management services (99495–99496): These services, which include both face-to-face and non-face-to-face efforts, are provided to established patients “whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting ... to the patient's community setting.”

Each of the new categories above includes comprehensive section guidelines to help you apply the codes correctly. Look to future editions of *Coding Edge* for a complete breakdown.

Anesthesia

The two changes in the Anesthesia chapter are part of a recurring theme for 2013; revised descriptors no longer limit reporting to physicians. For example:

01991 Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider physician or other qualified health care professional); other than the prone position

Hundreds of such descriptor changes occur throughout CPT®, in nearly every chapter.

Integumentary

There is just one change in the Integumentary section this year: Code 15740 (island pedicle flap) is revised to require identification and dissection of an anatomically-named axial vessel.

Musculoskeletal

Changes in this section include revisions to allow code reporting by “other qualified health care professionals,” as well as the inclusion of conscious sedation with percutaneous vertebroplasty (+22522). New codes describe arthrodesis by pre-sacral interbody technique with instrumentation (22586), and revision of total shoulder (23473–23474) and elbow (24370–24371) arthroplasties.

You'll find new text in the section guidelines throughout the chapter, including instructions to use modifier 76 *Repeat procedure or service by same physician or other qualified health care professional* when reporting "re-reduction of a fracture and/or dislocation performed by the primary physician or other qualified health care professional."

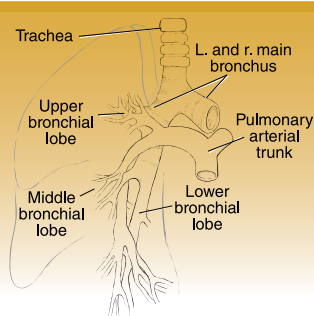
Respiratory

New codes 31647–31651 replace Category III codes 0250T–0252T for insertion and removal of bronchial valves to treat patients with emphysema or lung damage. Similarly, new Category I codes replace Category III codes for bronchial thermoplasty.

Outdated codes have been deleted, some replaced by new codes that more accurately describe the procedures performed. For example, new codes are now available for thoracentesis (32554, 32555) and pleural drainage (32556, 32557).

Finally, there's a new subsection and code (32701) for thoracic target delineation to identify tumor borders, tumor volume, and tumor relationship to adjacent anatomic structures. Delineation of the tumor allows the radiation oncologist to plan and deliver radiation treatments.

New codes 31647–31651 replace Category III codes 0250T–0252T for insertion and removal of bronchial valves to treat patients with emphysema or lung damage.



Cardiovascular

New codes 33361–33369 replace Category III codes 0256T–0259T for transcatheter aortic valve replacement. You will select the new codes based on whether the approach is open or percutaneous, and the vessel the surgeon uses for the approach.

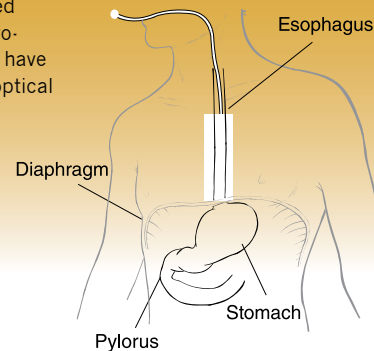
Category III codes 0048T and 0050T have been deleted and replaced with 33990–33993 for insertion, removal, and repositioning of percutaneous ventricle assist devices.

New codes 36221–36228 describe selective and non-selective arterial catheter placement and angiography in the aortic arch, and carotid and vertebral arteries. They include vessel access, placement of

catheter(s), contrast injection(s), fluoroscopy, radiological supervision and interpretation (S&I), and closure of the arteriotomy.

New and revised codes (e.g., 37197, transcatheter retrieval; 37211–37214, transcatheter therapy) now bundle radiological S&I services.

Mucosal cells are evaluated using an optical endomicroscope. Several new codes have been created to support optical endomicroscopy.

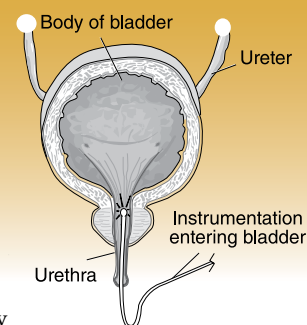


Digestive

Several new codes (e.g., 43206, esophagoscopy; 43252, upper gastrointestinal endoscopy) have been created to report optical endomicroscopy, which allows the provider to eliminate random sampling and perform targeted biopsies through real-time cellular observation of mucosal tissue. A new code (44705) reports preparation of fecal microbiota for instillation in a patient with *clostridium difficile* infection.

Urinary

Injections are made into the bladder for chemodenervation (code 52287).



In the Urinary section, you'll now find code 52287 for chemodenervation of the bladder.

Nervous System

In this section, chemodenervation code 64614 has been revised to specify "extremity" (singular). The procedure is reported once per session when treating a single extremity, regardless of how many in-

dividual injections are made. New code 64615 describes bilateral chemodenervation of muscle(s) innervated by facial, trigeminal, cervical spinal, and accessory nerves.

Percutaneous implantation of neurostimulator electrode array to the sacral nerve (64561) now includes image guidance, when performed.

Eye and Ocular Adnexa

Codes in this section have been revised to simplify reporting of paracentesis of the anterior chamber of the eye (now reported using 65800, exclusively). Code 67810 *Incisional biopsy of eyelid skin including lid margin* was revised to include the depth of tissue removed, to promote proper coding. Parenthetical instructions direct you to 11100, 11101, or 11310–11313 when reporting a biopsy for the skin of the eyelid.

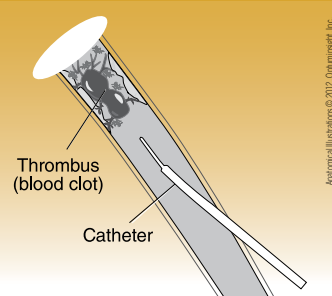
Radiology

Codes for bronchography (e.g., 71040, 71060) have been deleted for 2013: Computed tomography (CT) is now the standard of care replacing bronchography. Codes 72040–72052 for radiology examination of the cervical spine have been revised to include the number of views to accurately capture the work performed (e.g., 72050 *Radiologic examination, spine, cervical; 4 minimum or 5 views*).

Where radiological S&I is now bundled, the corresponding radiology codes have been deleted or revised. For example, new codes 37211–37214 describe infusion thrombolysis with radiological S&I; therefore, 75898 *Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis* was revised to exclude thrombolysis.

Where radiological S&I is now bundled, the corresponding radiology codes have been deleted or revised.

Thrombolysis (now described with new codes 37211–37214) is performed using intra-arterial or intravenous infusion.



Codes 78000–78011 have been deleted and replaced by 78012–78014 for thyroid nuclear medicine scans. New and revised codes 78070–78072 describe a greater array of parathyroid planar imaging procedures (including single-photon emission computed tomography (SPECT) and CT).

Pathology and Laboratory

The big changes here revolve around molecular pathology codes, over 100 of which were added to CPT® last year. This year we gain 13 new Tier 1 codes plus an unlisted molecular pathology procedure code (81479) with revisions to all nine Tier 2 (81400–81408) procedures. Guidelines have been added to the beginning of the codebook, with information about the history of the molecular pathology codes, instructions for use, and frequently asked questions to assist with proper code selection.

Codes 83890–83914 and 88384–88386 have been deleted and superseded by molecular pathology codes 81200–81479. All genetic testing code modifiers, previously listed in CPT® Appendix I and applied with “stacking codes” 83890–83914, also have been deleted.

A new subsection of codes (81500–81512, 81599), with guidelines, has been added to report multi-analyte assays with algorithmic analysis (MAAA), which use the results of assays (molecular pathology assays, fluorescent in situ hybridization assays, and non-nucleic acid-based assays) and other patient information, when appropriate, to calculate the patient’s probability of developing a specific condition.

Category III codes 0279T and 0280T have been deleted and replaced with Category I codes 86152–86153 to report testing for tumor cells circulating in the blood of cancer patients. A new code (86711) has been created for testing to detect the John Cunningham virus, and new codes 86828–86835 report testing for antibodies to human leukocyte antigens (HLA). New codes 87631–87633 describe nucleic acid tests performed to detect respiratory viruses, based on the number of targets for the test.

Medicine

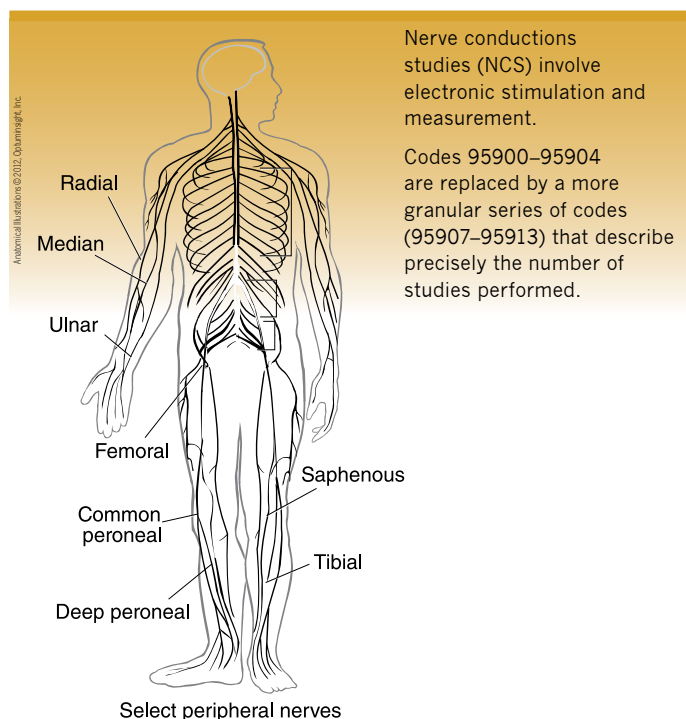
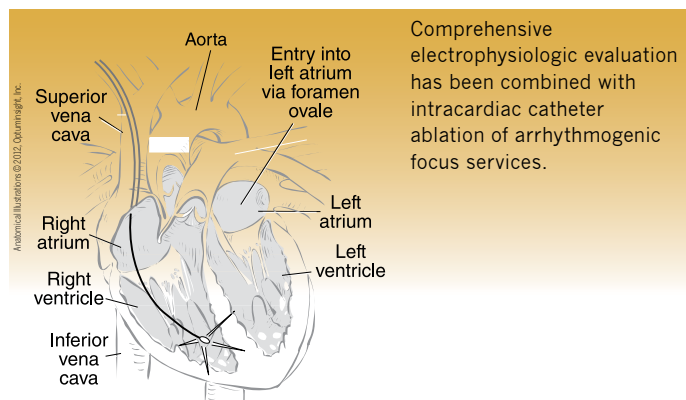
Dozens of codes in the Medicine section have undergone descriptor revisions similar to those in the E/M chapter, which allow the reporting of services by “other, qualified non-physician practitioners.”

Revised influenza vaccine administration codes (90655–90660) now specify “trivalent” vaccine, to clarify that the vaccine includes three viral strains. There is also a new code (90672) to report quadrivalent (four viral strains) influenza vaccine for intranasal use, and 90653 *Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use* is added to report the supply of adjuvanted seasonal trivalent influenza vaccine (currently awaiting FDA approval). Additional codes have been created or revised to report hepatitis B vaccines.

The psychiatry category received a major overhaul with the creation of new codes (e.g., 90832 *Psychotherapy, 30 minutes with patient and/*

or family member and 90839 *Psychotherapy for crisis; first 60 minutes*) and guidelines, as well as substantial code deletions. The revised code set more accurately reports the services behavioral health providers now perform.

Codes 92980, 92981, 92982, and 92984 have been deleted and replaced by 92920–92944 for coronary therapeutic services and procedures. New guidelines define the services and provide instruction on proper code use.



Editor's Note: More information regarding this information is available through AAPC's 4th quarter workshop "2013 CPT® Coding Updates." If you are unable to sign up for AAPC's workshop in a nearby location, you can register for an on demand workshop via www.aapc.com.

To combine comprehensive electrophysiologic evaluation with intracardiac catheter ablation of arrhythmogenic focus services, 93651 and 93652 have been deleted and four new codes (93653–93656) have been created.

Allergy testing codes 95010 and 95015 have been deleted and replaced with 95017 (venoms) and 95018 (drugs or biologicals).

In the neurology and neuromuscular procedures, polysomnography codes are now age specific (e.g., 95808, any age; 95810, age 6 years or older), and intraoperative neurophysiology monitoring code 95920 has been deleted, to be replaced by two new add-on codes: 95940 and 95941.

Lastly, nerve conduction studies are completely revamped: Codes 95900–95904 are replaced by a more granular series of codes (95907–95913) that describe precisely the number of studies performed (e.g., 95908 *Nerve conduction studies; 3–4 studies*). CPT® includes new subsection guidelines that specify, "For the purposes of coding, a single conduction study is defined as a sensory conduction test, a motor conduction test with or without an F wave test, or an H-reflex test."

Modifiers and Miscellaneous

CPT® 2013 contains no new modifiers, but modifier descriptors in Appendix B have undergone extensive revisions to include "other qualified health care professional" language and specify that modifiers may be appended to non-physician services, when appropriate.

In the Category II Codes section this year you will find seven new codes, six revised codes, and one deleted code. For additional information, consult the American Medical Association's (AMA) website at: www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.page?

Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC, is AAPC director of education. G.J. Verhovshek, MA, CPC, is managing editor at AAPC.



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

Look for coverage on Category III code changes in a future edition of *Coding Edge*.

ICD-10 IMPLEMENTATION BOOT CAMPS

FINAL TRAINING SCHEDULE

AAPC's boot camps are in final rotation and end June 27. If you haven't started preparing for ICD-10 implementation our two-day boot camp can get you on track. These are the LAST implementation training sessions before we transition to code set training and space will be severely limited.



2-Day Boot Camp Curriculum:

- Where to Begin – Organizing the Implementation Effort
- Understanding the Information Technology Impact
- What Needs to Change – Assessing Other Key Areas of Impact
- Identifying Documentation Challenges
- Building Your ICD-10 Action Plan
- Budgeting for ICD-10
- Planning Training Approaches and Resources
- Successfully Measuring Outcomes
- Introduction to ICD-10 Coding – Crosswalks and Mapping
- Hands-on Coding Exercises and Documentation Case Studies
- Templates, Tools, and Resources + Course Manual and ICD-10-CM Book

\$695

2-Days | 16 CEUs

REGISTER TODAY!

aapc.com/2012bootcamps
800-626-CODE (2633)

REMAINING IMPLEMENTATION BOOT CAMPS*

DATE	LOCATION	DATE	LOCATION	DATE	LOCATION
Dec 6	Seattle, Washington	Mar 7	Boston, Massachusetts	May 9	Long Beach, CA
Dec 6	Salt Lake City, Utah	Mar 14	Miami, Florida	May 16	Phoenix, Arizona
Dec 13	Atlanta, Georgia	Mar 16	Minneapolis, Minnesota	May 30	Baltimore, Maryland
Jan 17	Tulsa, Oklahoma	Mar 21	Cleveland, Ohio	Jun 6	Manhattan, New York
Jan 24	New Orleans, Louisiana	Mar 28	Nashville, Tennessee	Jun 20	Atlanta, Georgia
Feb 7	Houston, Texas	Apr 4	Denver, Colorado	Jun 20	Chicago, Illinois
Feb 21	Charlotte, North Carolina	Apr 11	San Francisco, California	Jun 27	Dallas/Ft. Worth, Texas
Feb 21	Kansas City, Missouri	Apr 25	San Antonio, Texas	Jun 27	Philadelphia, Pennsylvania
Feb 28	Washington, D.C.	May 2	St. Louis, Missouri	Jun 27	Seattle, Washington

*Dates and locations subject to change



For a complete list of all remaining boot camps, visit:

aapc.com/2012bootcamps

1-800-626-CODE (2633)

Your One Stop Shop for ICD-10 Resources

Contexo Media is an independent provider of revenue-enhancing solutions for medical practices to maximize their coding, reimbursement and compliance efforts. Thousands of health care professionals rely on Contexo Media's coding books, software, eLearning, educational workshops and ICD-10 training to stay on top of critical updates across the fast-changing medical landscape.

As an AAPC member, save 20% on our popular ICD-10 books!

- **2012 Advanced Anatomy and Physiology for ICD-10-CM/PCS**
This best-selling book takes you through all the body systems that ICD-10 uses and gives specific details about how ICD-10 is used to identify the appropriate diagnosis/condition. A quiz is available at the end of each section to test your knowledge of ICD-10!
- **2012 Best Practices for ICD-10-CM Documentation and Compliance**
This hands-on book identifies the additional ICD-10-CM documentation requirements using detailed checklists for all required documentation elements and documentation from medical/health records. Scenarios and end-of-chapter quizzes make this a hands-on learning experience, essential for ICD-10 training.

Use promo code
AAPC12 to save 20%!



REGULAR PRICE: ~~\$159.95~~
AAPC PRICE: **\$127.96**



REGULAR PRICE: ~~\$159.95~~
AAPC PRICE: **\$127.96**

Simply use promo code **AAPC12** to save 20% on these resources online at www.codingbooks.com or by calling 1-800-334-5724.

By Jim Denny, MBA

Manage Four Key Revenue Cycle Metrics

Improve your practice's financial health by analyzing your cash flow.

Every practice knows that cash flow is a key indicator of financial health, but other key metrics should be evaluated to see the true state of a practice. By regularly looking at the number of days in accounts receivable (A/R), A/R greater than 120 days, collection rate, and denial rate, for example, you can gain a much greater sense of how your practice is performing—and where it can improve. Each of these metrics can easily be calculated and analyzed to help improve your revenue cycle.

Formulate Number of Days in A/R

How many days a claim sits in A/R is perhaps the single most important revenue cycle metric; it tells a practice the number of days money owed remains unpaid. Although vital to any practice's finances, this statistic is not difficult to calculate. First, to properly account for volume, the calculation for days in A/R should feature outstanding dollars based on a practice's average daily charge. Next, follow these steps to correctly arrive at days in A/R:

- **Step 1:** Determine your total current receivables, and then subtract any credits. Credits are funds owed by the practice to others. They offset receivables, so subtract credits from receivables. Otherwise, days in A/R will appear overly optimistic.
- **Step 2:** Determine your average daily charge amount by dividing total gross charges for the last 12 months by 365 days (to represent the previous 12-month period).
- **Step 3:** Divide the total from Step 1 (receivables) by the total from Step 2 (charge amount).

Takeaways:

- Cash flow metrics can be easily analyzed.
- Formulate and monitor the number A/R days greater than 120.
- Keep denial rates low.

The formula looks like this:

$$\frac{(\text{Total Current Receivables After Credits})}{(\text{Average Daily Charge Amount})} = \text{Days in A/R}$$

In some cases—for example, after a new physician joins—a practice may want to calculate the average daily charge on a three-month, instead of a 12-month, period (just be sure to divide the previous three months by 90 days instead of 365 days). Either way is fine, as long as you use the metric consistently.

Days in A/R can mask areas of underperformance that practices should watch, including:

- *Payer-specific delays*—Overall days in A/R could be 45, but Medicaid claims might average 75 and warn of a problem that needs attention.

Tip: In addition to calculating overall days in A/R, also calculate it by payer to avoid missing potential problems.

- *Collection accounts*—Accounts sent to a collection agency are often written off the current receivables. As a result, they are not part of the days in A/R equation. Sending accounts to collections may improve days in A/R, but camouflage deeper issues.

Tip: Calculate days in A/R with and without accounts sent to collections to see a true picture of the situation.

1. Number of days in A/R

2. A/R greater than 120 days

3. Collection rate

4. Denial rate



A high internal claims rejection rate may actually predict a lower payer denial rate, which ultimately means improved cash flow.

- **Payment plans**—Payment plans allow days in A/R to rise by offering additional time for reimbursement.

Tip: Create and designate payment plans as a separate “payer.” That way, days in A/R can be calculated with or without payment plans taken into account.

- **Aged claims**—Good overall days in A/R still can hide elevated amounts in the older aging buckets (e.g., past 90 or 120 days).

Tip: Monitor these statistics separately.

On the whole, an A/R greater than 50 days generally indicates the need for improvement. Average practices usually see A/R of 35 to 50 days, with top performing practices often boasting A/R of less than 35 days.

Monitor Percentage of A/R Greater than 120 Days

The percentage of A/R greater than 120 days old (A/R > 120) is a measure of a practice’s ability to obtain timely reimbursement. As indicated earlier, it should be monitored with overall days in A/R for a more accurate view of revenue strength.

The formula to calculate percentage of A/R > 120:

$\text{Dollar Amount of A/R} > 120 \text{ from Date of Service} \div \text{Dollar Amount of Total A/R}$

An A/R > 120 greater than 25 percent indicates an area of weakness. Most practices average A/R > 120 between 12 and 25 percent,

while best performers may see A/R > 120 below 12 percent.

Tip: Make sure you base this calculation on the actual age of a claim (i.e., the date of service). Otherwise, if a claim is “re-aged” to “zero” every time it moves from one payer to another, a practice can end up with a falsely positive impression of performance.

Calculate Adjusted Collection Rate

The adjusted (or net) collection rate shows the percentage of collected reimbursement in comparison to the allowed amount based on a practice’s contractual obligations. In other words, it reveals how effectively a practice collects all legitimate reimbursement.

Calculate the adjusted collection rate this way:

$[\text{Payments (Minus Credits)}] \div [\text{Charges (Minus Approved Contractual Adjustments)}]$

Do this for a selected time frame. A practice that cannot accurately match payments with their originating charges may want to consider using data aged approximately six months to ensure most of the claims used in the calculation have cleared.

A common mistake is to include inappropriate write-offs in the calculation. This can happen when applying inappropriate charge adjustments while posting payments (for example, lumping non-contractual adjustments and contractual adjustments together). Solve this dilemma by distinguishing between the two sets of adjustments, and tracking contractual adjustments based on reason.

An adjusted collection rate less than 95 is considered poor. On average, practices have an adjusted collection rate between 95 and 99 percent, with high performers achieving an adjusted collection rate higher than 99 percent.

Keep Denial Rates Low

Denial rate is the percentage of claims denied by payers. The lower this number, the better a practice’s cash flow—and the less staff needed to maintain that cash flow. Automating processes through real-time eligibility tools and online claims editing capability, for instance, can lower this ratio dramatically.

The formula to calculate denial rate is:

$\text{Total Dollar Amount of Denied Claims} \div \text{Total Dollar Amount of Submitted Claims}$

Again, select the amounts from a designated time period. Practices may want to use denied charge line items, divided by total submitted charge line items.

Denial rates greater than 10 percent reveal weaknesses. Most practices experience denial rates between 5 and 10 percent, with top performers coming in with denial rates lower than 5 percent.

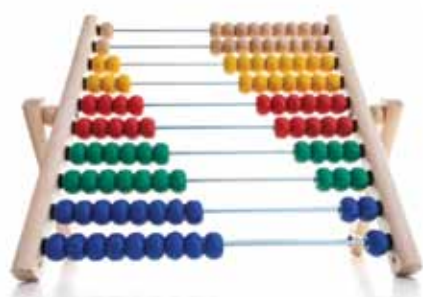
One denial rate “best practice” is to catch potential mistakes before claims go out the door. Well-run business offices edit charges—and reject claims—via internal systems before those claims are sent to a payer. A high internal claims rejection rate may actually predict a lower payer denial rate, which ultimately means improved cash flow. Using a clearinghouse or claims scrubber to spot errors offers a two-fold payback: A denial is prevented and a delay in final payment posting is avoided.

Assess Financial Strength

Ongoing monitoring of these key metrics is essential to improved revenue cycle performance. With the right tools, a practice can keep a steady eye on key revenue cycle metrics—and experience fewer denials, faster payment, and greater profitability. ■



Jim Denny, MBA, is founder, president, and CEO of Navicare, a leading medical claims clearinghouse.



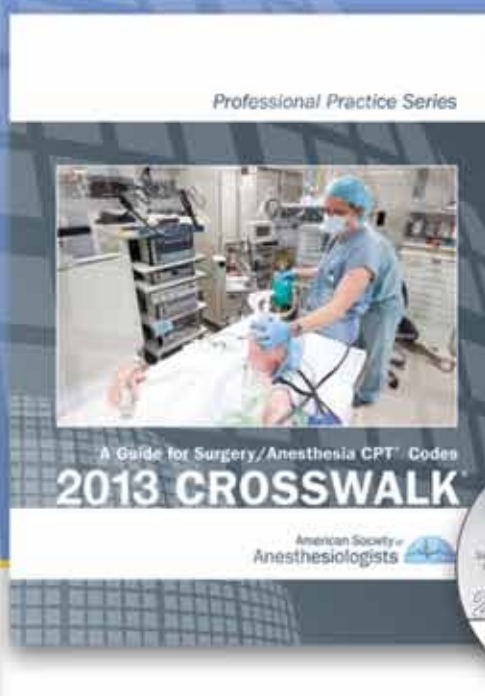
Anesthesia Coding Resources

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/EbOr6

American Society of
Anesthesiologists



Contracts Part II: Prepare and Analyze Data

Use gathered data to understand your practice's needs before approaching the payer.

The new year is nearly here. Time to get a fresh start on your payer contracts. Gather your year-end data and prepare yourself to approach payers for new agreements or rate updates.

Start with a High-level Perspective

After you've gathered the contracts and information from payer websites or their toll-free numbers (see Part 1, "Contracts: Start by Gathering Data," October 2012, pages 34-36), summarize the information at a high level. I recommend a summary format similar to the one shown in **Table 1**.

In this example, the payer, Alpha, is contracted with the practice through an independent practice association (IPA). The fees are 130 percent of a fixed base year of 2007 Medicare resource-based relative value system (RBRVS). The contract has been effective since Jan. 1, 2008, and this payer represents 17 percent of the practice's revenue.

You should gather similar information for each payer with whom you are contracted.

Takeaways:

- Begin working on your contract agreements for next year.
- Choose the right base year value to improve your revenue.
- Review your utilization data to assure your practice is getting paid properly.

Next, Analyze Reimbursement Details

Using this high-level summary, you can easily determine the base years of Medicare RBRVS you'll need to know to analyze current fees versus upcoming payer proposals.

The base years for this practice would be 2005 (non-Geographic Price Cost Indexed), 2007 (GPCI), 2012 (GPCI) Medicare RBRVS, and the 2011 state workers' compensation fee schedule. The Medicare fee schedules are available on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html).

With this data, complete a spreadsheet, which you can call the "Payer Resource Manual," and use the base year allowable and the current contracted payer amounts for our hypothetical practice, as shown in **Table 2**.

Each payer will likely address lab, X-ray, and supply codes differently. If no RBRVS payment exists, you could contact each payer for your contracted allowed amounts or pull explanation of benefits (EOBs) to find the paid amount. If the practice is heavily dependent on revenue from HCPCS Level II codes (such as durable medical equipment (DME), supplies, or injectables), it's worth gathering the invoices to know the acquisition costs.

Verify predicted payment on your Payer Resource Manual by code, and validate it against payer EOBs to confirm your spreadsheet is accurate. The confidence that comes with knowing as much as the payer does about your current contracted



... don't trust what an old, filed contract says your rates are: Verify the amounts against current payments.

Table 1: Summary of Data Collected from Payers

Payer	Contract Entity	Effective Date of Current Rates	Fee Schedule Base	Scheduled Update	Fee Schedule Percentage	Percent of Practice Revenue
Alpha HMO	IPA	1/1/2008	Fixed on 2007 RBRVS GPCI	N/A	130%	17%
Beta PPO	Direct, individual agreement	9/1/2006	Fixed on 2005 RBRVS, national	N/A	125%	16%
Delta Workers Comp	IPA	6/1/2011	Current year state workers' comp	Nov. 1	95%	14%
Gamma Plan	Direct, group agreement	1/1/2012	Current year (2012) GPCI RBRVS	April 15	110%	10%

Table 2: Payer Resource Manual

CPT® Code	Description	Frequency	Alpha HMO	Beta PPO (Individual Agreement)	Delta Workers Comp	Gamma Plan (Group Agreement)
Contracted Entity:			IPA	Direct	IPA	Direct
Most Recent Effective Date Provided:			1/1/08	9/1/06	6/1/11	1/1/12
		For	130%	125%	95%	110%
		Q1 2012	GPCI 2007 NF	2005 NF	2012 WC	GPCI 2012 NF
Office Visit Codes						
99201	Office/outpatient visit new	25	\$46.38	\$45.95	\$60.58	\$46.72
99202	Office/outpatient visit new	100	\$80.87	\$81.48	\$88.54	\$79.58
99203	Office/outpatient visit new	200	\$119.62	\$121.27	\$130.47	\$115.25
99204	Office/outpatient visit new	75	\$181.66	\$171.49	\$186.39	\$175.93
99205	Office/outpatient visit new	15	\$227.87	\$216.96	\$242.31	\$218.47
99211	Office/outpatient visit est	50	\$26.28	\$27.00	\$32.62	\$21.73
99212	Office/outpatient visit est	200	\$47.88	\$48.32	\$55.92	\$46.72
99213	Office/outpatient visit est	400	\$77.56	\$65.85	\$83.88	\$77.32
99214	Office/outpatient visit est	150	\$117.51	\$103.27	\$125.81	\$114.31
99215	Office/outpatient visit est	30	\$158.80	\$149.61	\$181.73	\$153.49

rates is the best way to start. In other words, don't trust what an old, filed contract says your rates are: Verify the amounts against current payments.

Learn by Example

Here's an example of how getting organized before you approach the

payers pays off. Knowing what 100 percent of the RBRVS is for codes that matter to the practice gives you a powerful position to counter payer fee schedule "updates."

In this client example, a radiation oncology practice was approached by a payer that represented a significant portion of the practice's



Table 3: 2005 and 2010 Medicare Allowables for Essential Codes

CPT®	Procedure	Current 2005	Proposed 2010	Percent Change
77263	Treatment planning	\$247.64	\$172.57	(30%)
77280-26	Simulation	\$55.84	\$37.59	(33%)
77290-26	Simulation	\$124.08	\$83.60	(33%)
77295-26	Simulation	\$358.28	\$245.81	(31%)
77300-26	Basic dosimetry	\$49.12	\$33.36	(32%)
77315-26	Isodose plan	\$124.08	\$83.60	(33%)
77332-26	Treatment device	\$43.43	\$29.14	(33%)
77334-26	Treatment device	\$97.20	\$66.35	(32%)
77427	Weekly treatment management	\$199.18	\$206.69	4%
77431	Treatment management (1 or 2 only)	\$143.21	\$104.69	(27%)
79005-26	R.T. - oral administration	\$90.45	\$94.73	5%

revenue. The payer wanted to update the contracted rates from a 2005 agreement, and proposed 2010 Medicare rates. A quick glance at the difference between 2005 and 2010 base year Medicare allowables for codes that were important to the practice enabled us to determine that 2005 was a much better paying base year (compared to 2010). **Table 3** shows how the update would impact several codes commonly reported by the practice.

Learn from History: It's the Best Predictor

You should know the most current period's utilization data for each payer by CPT® code. In the above client example, we used the practice's billing software to pull the past year's utilization of procedure codes for the payer in question. With the frequency count for each of these codes, the current payer's allowed amount, and the most current year (at the time of Medicare, we could see how the payer's attempt to "update" the practice using a more recent year's Medicare fee schedule would cost the practice a lot of money: an average 15 percent reduction. Using actual utilization, based on historical data from the practice (which is the best predictor of future utilization), the weighted impact averaged out to a 22 percent loss (because some high-volume codes had large decreases under the proposed rate).

Such a comparison isn't easy to set up in a spreadsheet, but having the data allows you to go back and forth as many times as necessary



to convince the payer not to subject the practice to such a loss after being a loyal network provider for so many years. Using this method, we were able to correct what would have been a \$33,000 loss to the practice and turn it into a \$4,000+ annual gain. This \$37,000 swing was well worth the time and effort to pull the data—and that was just one payer agreement!

Be Prepared for the Long Haul

When you have your current rates and past utilization defined, you're almost ready to approach the payers and begin the contracting process. Negotiations are an endurance test with many important steps. If you start naively, with no idea of the scope of the critical tasks and phases of the process, you're bound to burn out and give up. And any corners you cut in preparing will raise time-consuming issues later.

In the next installment of our contracts series, we will identify your practice's counterparts at your payers' and learn how to create an "alpha payer contact list" for your practice. [▶](#)



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



CodingWebU.com TM

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 70 Courses Approved for CEUs starting @ \$30

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



INGENIX



Health Care Quality and Value: The (R)evolution of the ACO

Part 2: As health care moves away from fee-for-service, quality care comes to the forefront.

Takeaways:

- ACOs are the result of the ACA and changes to SSA.
- ACOs base reimbursement on performance measure reporting.
- ACOs shift payment from how much care the patient receives to how good the care is received by the patient.

Evidence-based medicine (EBM) and the Physician Quality Reporting System (PQRS) have brought the concept of pay for performance (P4P) to health care. The (r)evolutionary next step driving quality and value is the accountable care organization (ACO). The concept of accountable care begins where P4P ends: More than offering incentives for quality care, it requires quality care as a condition of reimbursement.

ACOs 101

In October 2011, the U.S. Department of Health & Human Services (HHS) released a final rule governing the formation of ACOs. ACOs were implemented as a voluntary program in January 2012 as a result of the Affordable Care Act (ACA) and a modification to the Social Security Act (SSA), which established a funding source known as the Shared Savings Program. The ACO provisions represented only seven pages of the massive ACA; however, they were one of its most publicized provisions (along with the individual mandate).

Through the Shared Savings Program, the ACO initiative creates incentives for health care providers to work together to treat an individual patient across care settings, including physician offices, hospitals, and long-term care facilities.

Payers can form ACOs, and many have. UnitedHealthcare, Aetna, and Humana—each of which has vast experience with performance-driven care outcomes—have all formed ACOs. There are both commercial and Medicare ACOs. Many ACOs have been established by community-based programs and provider groups.

ACOs Require Performance Measure Reporting

ACOs seek to reduce health care costs, coordinate care, eliminate duplication of care, and prevent medical errors while ensuring better data integrity. ACOs meeting specific performance objectives over a three-year introductory period will share in any savings they create through lowered health care costs (versus estimated costs using a “traditional care” model). ACOs unable to meet the performance objectives will be penalized. The goal is to share in rewards and risk across all participants in the ACO.

Like PQRS and other quality monitoring programs, ACOs rely on data—much of which will be derived from patient charts by certified medical coders. The final rule adopts 33 individual measures of quality

performance used to determine if an ACO qualifies for incentive shared savings. These performance measures span four quality domains:

- Patient Experience of Care
- Care Coordination/Patient Safety
- Preventive Health
- At-risk Populations

Reporting conditions such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), vascular disease, risk for falls, diabetes, hypertension, tobacco cessation, depression, certain types of cancers, and immunizations all will depend on data provided by certified medical coders, and will help to determine if the ACO will share in savings or face penalties.

Moving Away from Fee-for-service

As a reimbursement methodology, ACOs are vastly different from traditional fee-for-service (FFS), which is the most common reimbursement methodology in the United States. In an FFS system, providers are paid based on the number of tests, treatments, surgeries, or studies they perform; hospitals are paid based on the number of beds they have occupied. The focus is on “how much” (quantity) care is provided, rather than “how good” (quality) the care is.

The concept of quality-based reimbursement (such as P4P) has existed for approximately 25 years, but has only begun to pick up steam in the past 10 years with the advent of the physician quality reimbursement initiative (now PQRS). If successful, the ACO

Editor’s note: This is the second installment of a three-part series on health care quality and value, and the future of health care reimbursement in the United States. Last month, we discussed the rise of evidence-based medicine, which promotes quality and value by encouraging “gold standards” in care delivery, and of performance reporting programs such as the PQRS.



Rather than being incentivized to deny expensive care, the ACO receives incentives for higher quality outcomes.

photo: Shutterstock/Maria Matus

model will revolutionize the way we receive, and pay for, health care in the United States.

ACO: HMO Take 2?

There are many differences between standard health maintenance organization (HMO) models and ACOs. When the Health Maintenance Organization Act of 1973 was passed and pioneered managed care, Americans were hesitant to allow Big Brother to oversee health care. It took nearly a decade for the managed care concept to catch on, but when it did, we learned that managing care saves money. There were, however, drawbacks in the way HMOs governed access to care. For example, HMOs are insurer driven and care can be fragmented; there is often little collaboration or co-operation in care delivery. There are gatekeepers—usually a provider that controls a patient's access to higher levels of care (which raises the often worrisome in-network versus out-of-network dilemma)—and the overall focus of HMOs and managed care remains on quantity rather than quality.

Unlike the HMO or managed care model, the ACO model is provider driven. Care is intended to be fully integrated and should occur more collaboratively. Team-based care is a primary tenet of the ACO. There are no gatekeepers in ACOs, and the overall focus is on the quality and efficiency of care. Rather than being incentivized to deny expensive care, the ACO receives incentives for higher quality outcomes.

There are risks associated with the ACO model. Early participants in ACOs are not fully weaned from of the FFS system, so



ACO remain an unproven reimbursement system. We are not likely to see quality-based outcome measures or quality-based financial incentives for a year or more.

Another potential danger is ACOs will engage in “cherry picking,” or choosing only the healthiest patients to treat. The Centers for Medicare & Medicaid Services (CMS) has announced they will penalize any ACO caught cherry picking, and there are protections built into the final rule so cherry picking ACOs stand to lose money. Concerns remain that this may not be enough to combat the problem.

Perhaps the greatest risk is that there are no gatekeepers: There is nothing requiring a patient to remain with an ACO. In other words, if a patient wants to obtain health care from providers outside the ACO, he or she may do so using traditional Medicare insurance. The ACO would be penalized for these out-of-network expenditures (pre-

sumably, if the ACO's quality of care and patient satisfaction are high enough, there would be no reason for a patient to seek health care elsewhere). This patient freedom represents a big gamble for fledgling ACOs.

The United States has yet to design a perfect health care system. If ACOs are to be successful, they must have a solid foundation with which to bridge the divide between FFS and accountable care. ■



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



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



Coders Dine on Knowledge, More in Chi-town

AAPC's Chicago Regional Conference cooks up quality education and unlimited networking opportunities.

AAPC's October Chicago Regional Conference had all the qualities of the city's famous hot dog: a lot of ingredients, interesting flavors all in one place, and satisfaction of time well spent.

It was the first conference for more than 60 percent of the attendees. **Amy Bishard, CPC, CPMA, CEMC**, said, "It was great to see so many people experiencing the fun, networking, and learning opportunities of an AAPC conference for the first time."

National Advisory Board (NAB) President **Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P**, said, "Having so many new attendees was HUGE and what the NAB, AAPCCA, and staff did to help things run smoothly was impressive." The "old-timers," as Stewart refers to experienced conference attendees like herself, "did an amazing job at making sure new attendees didn't get lost and knew exactly what was needed to have a successful conference."

With such a mix of new and old conference goers, Chicago's Hyatt Regency Hotel proved to be the perfect setting to talk about attendees' burning passion: coding.

The location was easy for members in all parts of the United States to congregate. Bishard said, "Besides planes and automobiles, many people were able to take the train or a shuttle to Chicago, which made this conference even more unique." Stewart added, "Attendees didn't have to spend a ton of money on cabs or to walk much at the venue because everything was close."

A Table of Quality Coding Education

The conference kicked off with a hearty welcome from AAPC Chairman and CEO Reed Pew, who ignited conference excitement and shed light on what's going on at AAPC and its future plans.

"As always, the quality of the educational programs was outstanding and presented a multitude of learning opportunities for all who



attended," said **Michael D. Miscoe, Esq., CPC, CAS-CC, CUC, CCPC, CPCO, CHCC**. Coding professionals interested in coding and billing, auditing and compliance, and practice management had the same quality education and array of choices as a national conference.

For attendees who were looking to see where coding and health care expertise can take them in their career path, "Evolutions in Coding Careers - Panel Discussion" had an open forum of panelists—**Betty Hovey, CPC, CPC-H, CPMA, CPC-I, PCPD, Melody S. Irvine, CPC, CPMA, CPC-I, CEMC, CFPC**, and **Maria Rita Genovese, CPC**—to answer questions. Some of the careers covered were management, consulting, auditing, billing, teaching, and business ownership.

ICD-10 Preparation: A Hot Dish

Even with the delay of ICD-10-CM to Oct. 1, 2014, coders benefited from the ICD-10 presentations. Bishard said, "AAPC definitely focused on what coders needed

to be doing to start getting ready."

There were both ICD-10 general and breakout sessions, which included basic information that coders need to know to prepare.

While all of the lectures were informative, the presentation that stood out as a real crowd pleaser was Betty Hovey's "Advanced Anatomy & Pathophysiology for ICD-10." Miscoe said, "The A&P general session for ICD-10 was exceptional and very informative."

G2KYLC Fires Up Local Chapters

Thursday night was the Get to Know Your Local Chapter (G2KYLC) event for attendees to stop by and network with other local chapters and the AAPC Chapter Association (AAPCCA). For this conference, the theme was "Get Fired Up with Your Local Chapter."

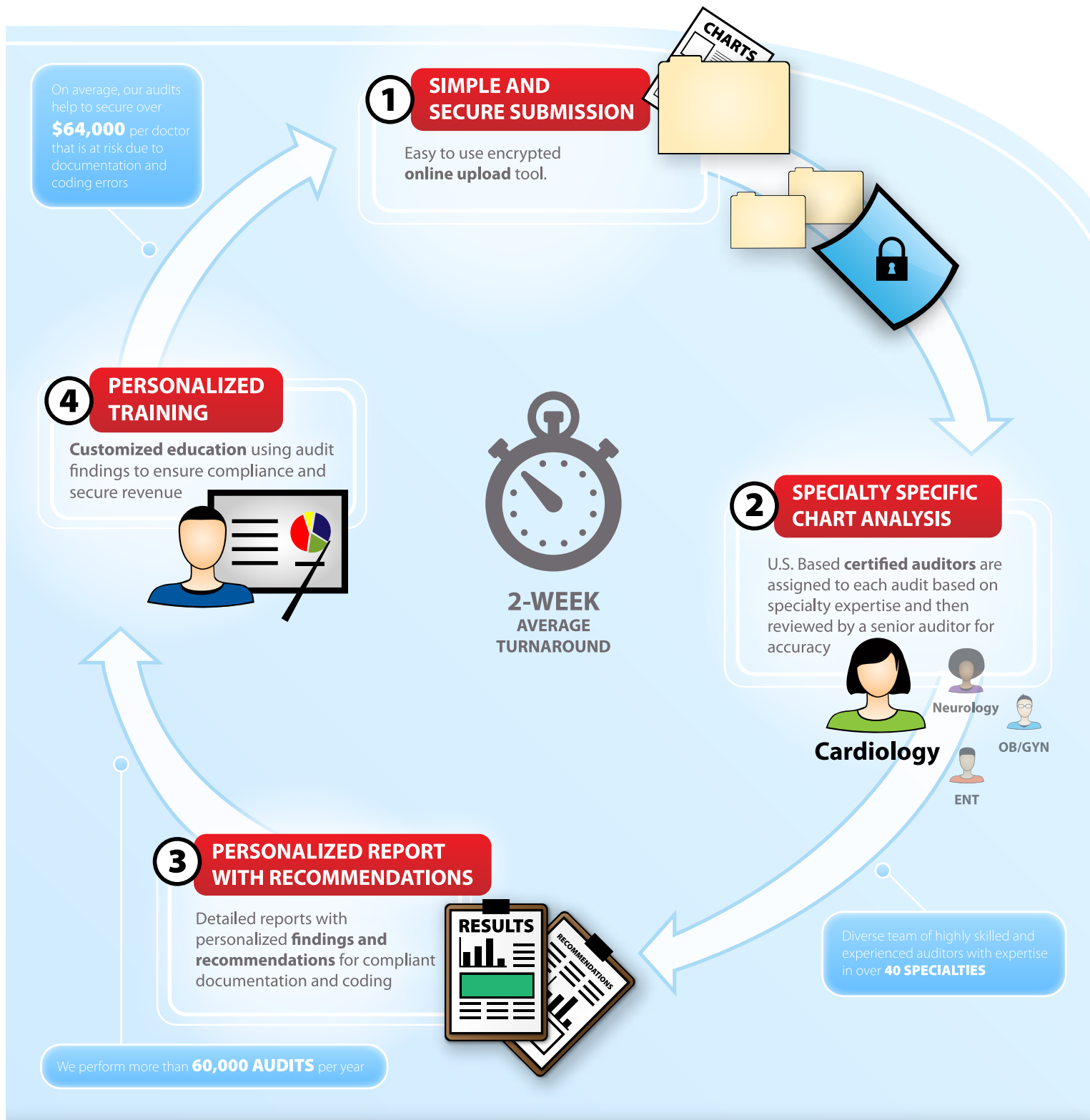
As conference attendees know, the most beneficial part of any conference is networking. Bishard said, "Having the opportunity to share knowledge and discuss experiences with others who work in the same field or specialty is something unique to conference."

The networking experience at conference is of "incalculable value" to Miscoe, as well. "I am really looking forward to the national conference in Orlando!" he said.

Michelle A. Dick is executive editor at AAPC.

EASE THE BURDEN OF YOUR NEXT CODING AUDIT

Given our experience in coding and auditing, AAPC Physician Services is the industry standard for chart reviews – making us the most cost effective and time efficient option to augment your internal audit team or fill an important skills gap.



**AAPC
PHYSICIAN SERVICES**
Compliant and Profitable Practices

CONTACT US TODAY
www.aapcps.com
866-200-4157

AVOID DENIALS when Reporting Unlisted Services and Procedures

Research and ask to find out what documentation your payers require.

Takeaways:

- Unlisted service and procedure codes can cause claims to be denied.
- Provide adequate documentation of the service or procedure to support use of the code.
- Suggest a reasonable reimbursement when filing the claim since fee schedules do not include unlisted codes.

When submitting claims involving unlisted services or procedures, you may experience claim denials routinely, even when special reports are included. Very often, you can avoid these denials by knowing your payers' specific requirements. For example, some payers have forms specifically for review of special reports when unlisted services or procedures have been rendered. This helps the payer to direct the claim properly.

You may receive an ambiguous denial, even when the payer requires very specific information. For example, your denial may state, "medical records needed." You send the office notes associated with the visit, only to have the claim denied again because it was actually an *X-ray report* that was needed. Don't get caught in that confusion: Ask the payer to explain *exactly* what's needed.

Regardless of what your payer's requirements are, follow them "to the letter" to make sure your provider is appropriately reimbursed—or at least to establish that the service/procedure has become an industry standard (more on this, later).

Know Necessary Requirements

Rendered services commonly require a special report because the CPT® and HCPCS Level II code sets do not specifically describe what was done. When submitting reports, consider highlighting or underlining the section that most identifies the procedure related with the unlisted code.

For example, **Table A** is a sample laboratory requisition in which the ordering physician has requested a prothrombin time with international normalized ratio (PT/w INR) as a STAT. This will justify the use of CPT® 99199 *Unlisted special service, procedure or report*.

Table A: Laboratory Requisition

Sample Order

- | | | |
|----------------|-----------------|------------------|
| ▫ Hematology | ▫ Urine test | ▫ Chemistry |
| ▫ Iron profile | ▫ Urine culture | ▫ Glucose |
| ▫ PT/INR-STAT | ▫ Microscopic | ▫ Hemoglobin A1C |

By highlighting **this information** and including it with your UB-04/CMS-1500, the payer is able to validate your reimbursement request. Consider also the category upon which the documentation requirements may fall, as shown in **Table B**.

Table B: Documentation Required for Codes

Category	Example	Documentation Type Needed
Pathology and Laboratory Procedures: Unlisted codes within the range of 80047-89398	CPT® 84999 <i>Unlisted chemistry procedure</i>	Pathology or lab report
Surgical Procedures: Unlisted codes between ranges 10021-69990	CPT® 30999 <i>Unlisted procedure, nose</i>	Operative report
Radiology/Imaging Procedures: Unlisted codes between 70010-79999	CPT® 76499 <i>Unlisted diagnostic radiographic procedure</i>	Imaging report
Unclassified Drug Codes	HCPCS Level II J3590 <i>Unclassified biologics</i>	Separate narrative description

Make a Payment Suggestion

Because unlisted procedure or service codes are not assigned specific relative value units (RVUs), payers do not have a "standard" rate at which to reimburse them. Be sure to request a specific reimbursement amount, or you may be subject to accept what the insurance company has decided to pay. To justify your charges, include with your special report a comparison between the provided procedure or service and the "next closest" CPT® or HCPCS Level II code. Include relevant details such as:

- Was the claimed unlisted procedure more or less difficult than the identified comparison procedure?



When appropriate, report Category III codes (rather than an unlisted procedure code), not with the objective of reimbursement, but instead to further the cause of regular code assignment, and to aid in data collection and utilization reporting.

- Did it take longer to complete (and if so, by how much)?
- Was there a greater risk of complication?
- How does post-operative care compare?
- If you're providing durable medical equipment (DME) or drugs, what is the supply cost?

Such details can make a difference in the reimbursement you receive.

Special Services and Adjunct Codes

Health care providers may also need a way to report services above and beyond the basic services rendered. CPT® codes 99000-99091 fulfill this need. For example, I work under POS 81 *Independent laboratory*, where providers order specific tests under a STAT request. In addition to CPT® 99199 (found in the Medicine section under "Other Services and Procedures") for the STAT, the claim will also include 99000 *Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory* for the pickup and transportation of the specimen.

Modifiers to Consider

As noted in the chart above, there are unlisted coding possibilities for DME and drug-related items. For orthotics and prosthetics, consider including modifier NU *New equipment* for any new DME not commonly billed (e.g., E0988 *Manual wheelchair accessory, lever-activated, wheel drive, pair*). This will help the payer when reviewing the documentation you included for reimbursement considerations. Check with the payer before submission to see if they have dedicated forms for these claim types. This ensures the information will be routed to the personnel qualified to perform a review of your documentation.

Category III vs. Unlisted Procedure Codes

As you know, unlisted procedure codes in the CPT® codebook often end in 99 (e.g., 15999 *Unlisted procedure, excision pressure ulcer*) and appear last in a list of similar and/or anatomically related procedures (usually under the heading "Other Procedures"). But not all medical services absent a specific CPT® code should be assigned an unlisted procedure code.



If an unlisted procedure code has been submitted, the payer may deny your claim citing that a more appropriate service code is available. These codes may come from CPT® Category III, and are distinguished by a "T" suffix

(e.g., 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*). The "T" signifies the clinical efficiency and outcome of such emerging technologies has been considered temporarily.

When appropriate, report Category III codes (rather than an unlisted procedure code), not with the objective of reimbursement, but instead to further the cause of regular code assignment, and to aid in data collection and utilization reporting. This helps to prevent the temporary code from falling victim to the five-year sunset period. Consistent, appropriate reporting of Category III codes is key in the CPT® Editorial Panel's consideration for permanent codes.

5010 Compliance

The Health Insurance Portability and Accountability Act (HIPAA) Version 5010 implementation guide advises that any procedure performed with "unlisted" included in the descriptor must include a corresponding description of the services rendered. With HIPAA 5010 formatting now in effect, check with your electronic health record (EHR) billing vendor to see if there is a way to upload this information upon claims submission. The objective is to remain HIPAA compliant and give payers no reason to deny your claims, or to request even more documentation. Although medical records are requested routinely, some payers will not accept amended information after a certain time. Keep this in mind and provide proper documentation the first time around. ■



John S. Aaron Jr., CPC, is a senior client billing representative for the Chicago Business Unit of Quest Diagnostics. He is president-elect for the Northbrook, Ill. local chapter and a member of Medical Billing Advocates of America, specializing in the area of patient advocacy.

newly credentialed members



Aida Mercado, **CPC**
 Alda Savic Chapman, **CPC**
 Alice Surgen, **CPC**
 Alicia A Amett, **CPC**
 Allison Disessa, **CPC**
 Alysa Renee Coppinger, **CPC**
 Amanda Erhardt, **CPC**
 Amanda Rochier, **CPC**
 Amber Jane Hicks, **CPC**
 Amrutha Jayachandran, **CPC**
 Amy Liu, **CPC**
 Amy Wissinger, **CPC**
 Ana Barba, **CPC**
 Ana M Guerra, **CPC**
 Anand K Kumar, **CPC, CPC-H**
 Andrea Harter, **CPC-H**
 Andrea Hensley, **CPC**
 Angela Marie Burgo, **CPC**
 Angela Rassman, **CPC**
 Angela S Blunk, **CPC, CPMA**
 Angie Bayne, **CPC-H**
 Angie Pritchett, **CPC**
 Anna Merri McGregor, **CPC**
 Antonio Bozeman, **CPC**
 April Pritchett, **CPC**
 Arlene Jeanette Bundy, **CPC, CPC-H**
 Ashley A Laughlin, **CPC**
 Atish Suresh Sawant, **CPC**
 Autumn Herb, **CPC**
 Barry Allison, **CPC**
 Becki Saylor, **CPC**
 Becky Mitchell, **CPC**
 Belinda Kramer, **CPC**
 Beth Anne Current, **CPC**
 Betty Martin, **CPC**
 Blair Wente, **CPC**
 Bobbe Jo Lerner, **CPC**
 Brandee Kelley, **CPC**
 Brenda Baldwin, **CPC**
 Brenda Lee Miltso, **CPC**
 Brenda Threlloff, **CPC**
 Candy K Weinper, **CPC**
 Carlos Motta, **CPC**
 Carol Formisano, **CPC**
 Casey Nowakowski, **CPC**
 Cassandra Rush, **CPC**
 Catherine Warren, **CPC**
 Cathy Jean Solis, **CPC**
 Charles David Gray, **CPC**
 Chelle L Johnson, **CPC**
 Cheryl L Heizmann, **CPC**
 Christie Lynn Maxwell, **CPC**
 Christin Bishop, **CPC**
 Christina Ruiz, **CPC**
 Christine M Liberti, **CPC**
 Christopher W Schenk, **CPC, CPC-H**
 Connie Ahrens, **CPC**
 Connie Jackson, **CPC**
 Crystal A Huggins, **CPC**
 Crystal Burney, **CPC**
 Crystal Davis, **CPC-H**
 Cynthia Ann Colangelo, **CPC, CPC-H**
 Cynthia Kay Spears, **CPC**
 Cynthia M Blake, **CPC**
 Darla R McKnight, **CPC**
 David Hillman, **CPC**
 Dawn L Ford, **CPC**

Deanna Stephenson, **CPC**
 Debbie Perez, **CPC**
 Debbie Via, **CPC**
 Deborah Broyles, **CPC**
 Deborah Stephens, **CPC**
 Deborah Norris, **CPC**
 Deborah Salyers, **CPC**
 Debra Smith-Greene, **CPC**
 Deidra Harris, **CPC, CPC-H**
 Denise Knapp, **CPC**
 Diana McDonnel, **CPC**
 Diana Orellana, **CPC**
 Donna Harper, **CPC**
 Donna J Savage, **CPC**
 Donna Malone, **CPC**
 Elizabeth A Esposito, **CPC**
 Elizabeth B Lugo, **CPC**
 Elizabeth Daniel, **CPC**
 Elizabeth Lawrence, **CPC**
 Elizabeth Lea Osborne, **CPC**
 Erica Lynne Folker, **CPC**
 Erica Schlick, **CPC**
 Erin Gorham, **CPC**
 Erin Kuhr, **CPC**
 Erin Malmquist, **CPC**
 Erna Lee Gabbard, **CPC**
 Estella M Rohm, **CPC**
 Eunice Parbo Racpan, **CPC**
 Euniece Mansanarez, **CPC**
 Evelyn Marie Wozniak, **CPC**
 Flor G Ceja, **CPC**
 Gabriela Craciunec, **CPC**
 Gail Gordon, **CPC**
 Ginny Mathews, **CPC**
 Gloria Lebel, **CPC**
 Heather Maggo, **CPC**
 Heather Shiffer, **CPC**
 Helen Louise Bolton, **CPC**
 Hope E Dendy, **CPC, CPC-P**
 Hope Land, **CPC**
 Ilene Lundell, **CPC**
 Iris Melecio, **CPC**
 Jacqueline Ann Pauley, **CPC, CPC-H**
 Jamie Brown, **CPC**
 Jamie Meurer, **CPC**
 Janaea Croyle, **CPC**
 Janice Gagan, **CPC**
 Jeannette Michelle Rodriguez, **CPC**
 Jeannie Mendoza, **CPC**
 Jennifer R Wood, **CPC**
 Jennifer Sapp, **CPC**
 Jennifer Steen, **CPC**
 Jennifer Strom, **CPC**
 Jenny Chacon, **CPC**
 Jenny Jackson, **CPC**
 Jessica Ann Dockery, **CPC**
 Jessica Hernandez, **CPC**
 Jessica Luz, **CPC**
 Jessica Schuster, **CPC**
 Jill Ambler, **CPC**
 Jo Lynne Sage, **CPC**
 Joan Kegerize, **CPC**
 Joan Warner, **CPC-H**
 JoAnn Thomas, **CPC-H**
 Jody Wegesin, **CPC, CPC-H, CEDC**
 Joe Tucker, **CPC**
 Judith Konstans, **CPC**

Judith McNeerney, **CPC**
 Julie Leung, **CPC**
 Julie Ana Gardella, **CPC**
 Julie Michelle Schiltz, **CPC**
 Julie Pruyn, **CPC**
 Julie Ropcke, **CPC**
 Kaitlen Elizabeth Niernmeyer, **CPC**
 Kalaiselvan Chinnadurai, **CPC**
 Kalaiyani Macharaja, **CPC**
 Karen Blaloskurski, **CPC**
 Karen Koloski, **CPC**
 Karen Lojek, **CPC-H**
 Karen Mann, **CPC**
 Karen Waite Stifits, **CPC**
 Kathleen Elizabeth Schott, **CPC**
 Kathryn Alice Logan, **CPC, CPC-H, CANPC**
 Kathryn Lambert-Gorwyn, **CPC**
 Kathy Cusumano, **CPC**
 Kathy Shimer, **CPC**
 Kay Propst, **CPC**
 Kelle Humphries, **CPC**
 Kellie Marie Geisler, **CPC**
 Kelly Dobie, **CPC**
 Kelly Halterman, **CPC**
 Kelly Levandoski, **CPC**
 Kim L Coulthurst, **CPC**
 Kimberly Ann Vickery, **CPC**
 Kimberly Millard, **CPC**
 Kimberly Smith, **CPC**
 Kimbra Lee Freeman, **CPC**
 Krishna Kishore Panuganti, **CPC**
 Kristi Gentry, **CPC**
 Kristi Howsare, **CPC**
 Kristie Aweritt, **CPC**
 Kristin Lopez, **CPC**
 Kristina Ashton Braden, **CPC**
 Kristy Fletcher, **CPC**
 Kristy Huse, **CPC**
 Kumaravel V Venkatesan, **CPC**
 LaFleche Gosseline, **CPC**
 Lakesha M Parrish, **CPC, CPC-H, CEDC**
 Laletha Lychale Shabazz, **CPC**
 Lataya Matthews, **CPC**
 Latoy Ann Marie Anderson, **CPC**
 Laura Roe, **CPC**
 Laura Simon, **CPC**
 Lauren Maza, **CPC**
 Lesa Pendergrass, **CPC**
 Linda Wright, **CPC**
 Linda Amarante, **CPC**
 Linda LaVerne Thomas, **CPC**
 Linda P Meek, **CPC**
 Linda Tangney, **CPC**
 Lisa DeLena, **CPC**
 Lisa Elizabeth Skeval, **CPC**
 Lissa Carolina Carreras, **CPC**
 LuAnn Twelt, **CPC**
 Lynn Graham, **CPC**
 Madhubala Chinnappa, **CPC**
 Madhuri Kunche, **CPC**
 Mahalakshmi Vaithilingam, **CPC, CPC-H**
 Mandy Hubbard, **CPC**
 Maria Galo-Parrilla, **CPC**
 Marilyn Dickerson, **CPC**
 Maritese Monti, **CPC**
 Mark Kozu, **CPC, CPC-H**
 Marla Peak, **CPC**

Martha Sanchez, **CPC**
 Mary A Gillis, **CPC**
 Mary Claire Yap, **CPC**
 Maureen Amoroso, **CPC**
 Maureen Tracy Matera, **CPC**
 Mechelle Foster, **CPC**
 Melissa Blackstone, **CPC**
 Melissa J Long, **CPC**
 Melissa Ruth Moore, **CPC**
 Melissa Shipp, **CPC**
 Melody Dykes, **CPC**
 Mia Y Reddick-Smith, **CPC, CPC-H, CPC-I**
 Michelle A Palmer, **CPC, CPC-H**
 Mylinh Vu, **CPC**
 Nadezhda Rudenya, **CPC**
 Naila Garcia, **CPC**
 Nancy Hildebrand, **CPC-H**
 Nancy Browner, **CPC, CEMC**
 Nancy Heater, **CPC**
 Nancy J Sherman, **CPC**
 Nasira Seide, **CPC-H**
 Natasha R Hillhouse, **CPC**
 Nathalie Ordanza, **CPC**
 Nichole D Merschman, **CPC-H**
 Nichole Sparks, **CPC**
 Nicole Ann Schmucker, **CPC**
 Nicole Balcerzak, **CPC**
 Pam Davis, **CPC**
 Pamela Minkler, **CPC**
 Patricia Lynn Elliott-Kashima, **CPC**
 Paula Faber, **CPC**
 Pedro Ortiz, **CPC**
 Penny Louise Drabick, **CPC**
 Rachel Antoinette Simon, **CPC**
 Rachel Bigger, **CPC**
 Rachel Silansky, **CPC**
 Rachel Turner, **CPC**
 Raji Navamani, **CPC**
 Rebecca Tripp, **CPC**
 Rekni McGuire, **CPC**
 Renata Pierro, **CPC**
 Rhonda Thrift, **CPC**
 Rileene TK Waalani, **CPC**
 Robin M DeKorne, **CPC**
 Rogelio Cabrera, **CPC**
 Ronda Shouse, **CPC**
 Rose A Pazzi, **CPC**
 Roseann Cashin, **CPC**
 Sabrina Narcissa Pacheco, **CPC**
 Sailaja Subramanian, **CPC**
 Samantha Augustus, **CPC**
 Samantha Overfield, **CPC**
 Sandra Cross, **CPC**
 Sandra Lynch, **CPC**
 Sandra Marie Hayes, **CPC**
 Sandra Neel, **CPC**
 Sandra Pereira, **CPC**
 Sandy E Miller, **CPC**
 Sangeetha Elugam, **CPC**
 Sara Michelle Schropp, **CPC**
 Sarah Feazel, **CPC**
 Seth Saunders, **CPC, CPC-H**
 Shameka LaShawn Lathom, **CPC**
 Shanna L Speal, **CPC, CPC-H**
 Shanna Sebastian, **CPC**
 Shannon Campbell, **CPC**
 Shannon Terry, **CPC**

Shari Lynn Jacobs, **CPC**
 Shawna Renee Walker, **CPC**
 Shelly R Feliciano, **CPC**
 Sheri Marie Nink, **CPC**
 Sherry A Chapman, **CPC, CPC-H**
 Shymeka Lewis, **CPC**
 Sophia Dolores Johnson, **CPC**
 Sourmya PS, **CPC**
 Stacey Ferguson, **CPC**
 Stefani R Scollise, **CPC**
 Susan Michelle Gamble, **CPC**
 Susan Garside, **CPC**
 Susan Kraft, **CPC**
 Takeeta Sumner, **CPC**
 Tammy Bielecki, **CPC**
 Tammy Hollar Colwell, **CPC**
 Tara Murdock, **CPC**
 Tatiana Kouznetsova, **CPC**
 Tempest Williams, **CPC**
 Teresa Dawn Killmeyer, **CPC**
 Teresa Lynn Collins, **CPC**
 Teresa Mallory, **CPC**
 Teri Bedard, **CPC**
 Theresa Alvarez, **CPC**
 Theresa F Underwood, **CPC**
 Tiffany Bratcher, **CPC**
 Tiffany Gomez, **CPC**
 Tiffany Yelle, **CPC**
 Tina Yearout Smith, **CPC**
 Tonya Jacobs, **CPC**
 Tracy Noe, **CPC**
 Trinity Schrieber, **CPC**
 V Mishelle Jenkins, **CPC**
 Valerie Henderson, **CPC**
 Vicki L Hootman, **CPC**
 Vinoth Kumar Padmanathan, **CPC-H**
 Vinothkumar Jayaraman, **CPC, CPC-H**
 Vonetta L Whitehurst, **CPC**
 Wanda Arnett, **CPC**
 Yanepsy Santos, **CPC**
 Yolanda Viqueira, **CPC**
 Zhuljeta Shyti, **CPC, CPC-H**

Apprentices

Abbey E Ceci, **CPC-A**
 Abbey Rollins, **CPC-A**
 Agnes Merlin, **CPC-A**
 Aimee Kuykendall, **CPC-A**
 Ajina Abhilash, **CPC-A**
 Alaina Ann Denz, **CPC-A**
 Alden Wells-O'Dwyer, **CPC-A**
 Aldrin Rustia Gulay, **CPC-A**
 Aleen Lozier, **CPC-A**
 Alex Colley, **CPC-A**
 Alexis Williamson, **CPC-A**
 Alice Heele, **CPC-A**
 Alice Wetzel, **CPC-A**
 Alicia Andrus, **CPC-A**
 Alicia Ann Slater, **CPC-A**
 Alicia Leali, **CPC-A**
 Alicia Lynette Steward, **CPC-A**
 Alisa Allen, **CPC-A**
 Alisha A Evans, **CPC-A**
 Allison Lee, **CPC-A**
 Alysa Major, **CPC-A**
 Alyssa Lynn Weaver, **CPC-A**
 Alyssa Stine, **CPC-A**

Amanda Andruscavage, CPC-A	Beth Oman, CPC-A	Daisy D Portante, CPC-A	Elizabeth Craig, CPC-A	Jamie Ortega-Silva, CPC-A
Amanda Crawshaw, CPC-A	Beth Osborne, CPC-A	Dale Audean Cox, CPC-A	Elizabeth Dawn Avery, CPC-A	Jan Micheal Benigay, CPC-A
Amanda J Andrews, CPC-A	Bethany JoEllen Whitworth, CPC-A	Dana Harada, CPC-A	Elizabeth Frankhouser, CPC-A	Jane Reinhart, CPC-A
Amanda J Marsha, CPC-A	Betty Reid, CPC-A	Dana M Dunn, CPC-A	Elizabeth Franklin, CPC-A	Jane Butzko, CPC-A
Amanda Partaledis, CPC-A	Beverly Curt, CPC-A	Danielle Ortwine, CPC-A	Elizabeth Kreis, CPC-A	Jane Harry, CPC-A
Amanda Sue Daines, CPC-A	Beverly-Ann Lim-Avalan, CPC-A	Danielle Studer, CPC-A	Elizabeth Leslie, CPC-A	Jane Roffers, CPC-A
Amber Waid, CPC-A	Bianca Janelle Talley, CPC-A	Darlene Loznycky, CPC-A	Elizabeth Mahalik, CPC-A	Janet Kerns, CPC-A
Amber Flory, CPC-A	Brandi Frey, CPC-A	Darrel Winchester, CPC-A	Elizabeth Paul, CPC-A	Janet Gaier, CPC-A
Amber Greene, CPC-A	Brandi Schmitz, CPC-A	David Diaz, CPC-A	Elizabeth Perez Wilson, CPC-A	Janet Partin, CPC-A
Amber J Fitzwater, CPC-A	Brandon Chamire Chase, CPC-A	David Hammond, CPC-A	Elizabeth Williams, CPC-A	Janet R Brown, CPC-A
Amber Lynn Haidet, CPC-A	Breanna Elaine Grandstaff, CPC-A	David Petersen, CPC-A	Eric Alvarez, CPC-H-A	Janette Vega, CPC-A
Amber Zvolinski, CPC-A	Brenda Hopkins, CPC-A	David Wright, CPC-A	Eric Kears, CPC-A	Jaya Saha, CPC-A
Amberly Perles, CPC-A	Brenda Jones, CPC-A	David Ringler, CPC-A	Erica Ritchey, CPC-A	Jayanthi Arumugam, CPC-A
Ambika Dinakaran, CPC-A	Brenda Naeyaert, CPC-A	Dawn Davis, CPC-A	Erica Taylor, CPC-A	Jean Womack, CPC-A
Amy Deer, CPC-A	Brian Allen Claeys, CPC-A	Dawn Lynn Bennett, CPC-A	Erin Albertson, CPC-A	Jeanette Greene, CPC-A
Amy K Russell, CPC-A	Brian John McGarrah, CPC-A	Dawn Packer, CPC-A	Erin Bakken, CPC-A	Jeanne Breitung, CPC-A
Amy Keiser, CPC-A	Brian Pinkosky, CPC-A	Dawn Taylor, CPC-A	Erin Seed, CPC-A	Jeffrey Stanley Keilholz, CPC-A
Amy Laura McClellan, CPC-A	Brittany DeFazio, CPC-A	Dayna Fisher, CPC-A	Esther Linne' Mussoni, CPC-A	Jeffrey Valera Rabaino, CPC-A
Amy Parker, CPC-A	Brittany E Kimble, CPC-A	Deanna Brown, CPC-A	Ethel Fitzgibbons, CPC-A	Jenekia Latonia Thompson, CPC-A
Amy Peavler, CPC-A	Caitlin M Johnson, CPC-A	Deanne Sayers, CPC-A	Faisal shaik sayeed Bakhteeb, CPC-A	Jennifer Salyers, CPC-A
Ana Almeida, CPC-A	Cara Edwards, CPC-A	Deanne Ulrich, CPC-A	Fariborz Shams, CPC-A	Jennifer Blythe, CPC-A
Ana Garcia, CPC-A	Carena Christiansen, CPC-A	Debbie Baker, CPC-A	Felix Segre, CPC-A	Jennifer DeLong, CPC-A
Anbarasi Baskaran, CPC-A	Carol Baron-Sebesta, CPC-A	Deborah Davidson, CPC-A	Fernie J Sutherland, CPC-A	Jennifer I Spencer, CPC-A
Andre Demetrius Reed, CPC-A	Carol Jean Heidenreich, CPC-A	Deborah Anne Kerns, CPC-A	Filipe Cotas, CPC-A	Jennifer M Candelario, CPC-A
Andrea Shantel Burnett, CPC-A	Carol Jensen, CPC-H-A	Deborah Dyson, CPC-A	Firouzgh Ghazizadeh, CPC-A	Jennifer Munn, CPC-A
Andrea Stiller, CPC-A	Carol Murphy, CPC-A	Deborah Evans, CPC-A	Fola Dare, CPC-H-A	Jennifer R Sylvain, CPC-A
Andrea Wright, CPC-A	Carol Park, CPC-A	Deborah Kathy Thacker, CPC-A	Fouzia Qurbani, CPC-A	Jennifer Rene Gardner, CPC-A
Angel Knights, CPC-A	Carolyn Elaine MacMahon, CPC-A	Deborah L Moyer, CPC-A	Frances Marie Choiniere, CPC-A	Jennifer Wertz, CPC-A
Angela Banks, CPC-A	Carolyn Gibbs, CPC-A	Deborah Wittrock, CPC-A	Gabriel Paulus, CPC-A	Jenny Greenwood, CPC-A
Angela D LeMasters, CPC-A	Carrie Decker, CPC-A	Deborah Lynn Wolfe, CPC-A	Gail Olin, CPC-A	Jeremy Muha, CPC-A
Angela L Harris, CPC-A	Cassandra McClennan, CPC-A	Debra Johnson, CPC-A	Gale Lamanilao, CPC-H-A	Jessica Klapp, CPC-A
Angela Mitchell, CPC-A	Cassandra Nicole Widener, CPC-A	Debra Lorraine Miller, CPC-A	Galina Kolykhalova, CPC-A	Jessica Cuddy, CPC-A
Angelita Ruiz, CPC-A	Catherine Ivy Cruz, CPC-A	Debra Lucas, CPC-A	Gary Allen, CPC-A	Jessica Golden, CPC-A
Anglea Miles, CPC-A	Catherine T Wood, CPC-A	Debra Marquis, CPC-A	Gary Pemberton, CPC-A	Jessica Juliana Rosas, CPC-A
Anil Kumar Mala, CPC-A	Cathy Dixon, CPC-A	Delisa Blake, CPC-A	Gayla Renee Lancaster, CPC-A	Jessica Knauff, CPC-A
Anita Meraz, CPC-A	Cathy Rae Buis, CPC-A	Delores M Kerber, CPC-A	Gaynell Christie, CPC-A	Jessica Michael, CPC-A
Anitha Evangeline, CPC-A	Cecilia Fierro, CPC-A	Denice Williams, CPC-A	Georgette Catalano, CPC-A	Jeyalakshmi Sathiamoorthy, CPC-A
Anjie Perron, CPC-A	Celina A Cesare, CPC-A	Denise A Beckett, CPC-A	Georgia Palioungas, CPC-A	Jeyamary Jayapaul, CPC-A
Ann Lewis, CPC-A	Chandra Marie Shockley, CPC-A	Denise A Lemke, CPC-A	Geraldine B Ramos, CPC-A	Jillian Russell, CPC-A
Anna Miller, CPC-A	Charles Wrightington, CPC-A	Denise Duval, CPC-A	Gianina Barreca, CPC-A	Joann Leah Coffey, CPC-A
Anne Onafowokan, CPC-A	Chelsey Jermeay, CPC-A	Denise Fritzinger, CPC-A	Gianina Fisher, CPC-A	Jodi Ingram, CPC-A
Anne Bryant, CPC-A	Chelsie McBride, CPC-H-A	Dhanamjayakkumar Swithaganesan, CPC-H-A	Gina Geraltowski, CPC-A	Jodie Pataray, CPC-A
Annette Taylor, CPC-A	Cheryl Sicking, CPC-A	Dhanya Mary Alukunnathu Emmanuel, CPC-A	Glenda Rayburn, CPC-A	Jody DeMarea, CPC-H-A
April Gish, CPC-A	Cheryl Buckingham, CPC-A	Diana Watchorn, CPC-A	Glenda Scott, CPC-A	Joel Newsome, CPC-A
April Marie Weyland, CPC-A	Cheryl Conter, CPC-A	Diane Watson, CPC-A	Gloria Ayassou, CPC-A	Johanna G Reed, CPC-A
Aristotle B Gamboa, CPC-A	Cheryl Lynn Tenney, CPC-A	Diane Schoenrock, CPC-H-A	Guia Zhao, CPC-A	John Gartling, CPC-A
Arietta Bendschneider, CPC-A	Chloe E Egan, CPC-A	Diane Weyrens, CPC-A	Hailey Ann Allred, CPC-A	Jomarie Willis, CPC-A
Arthi Ranganathan, CPC-A	Chris Alan Nauss, CPC-A	Dina Mills, CPC-A	Hannah Dufur, CPC-A	Josefine Tsangaris, CPC-A
Arthur Dawsey, CPC-A	Chris Nagomy, CPC-A	Dolores Cavasos, CPC-A	Hannah Langley, CPC-A	Joseph Benedict Geraci, CPC-A
Ashley Carrier, CPC-A	Christie Jackson, CPC-A	Dominique Brock, CPC-A	Hardeep Kohli, CPC-A	Joseph Khan, CPC-A
Ashley Davis, CPC-A	Christina Gardner, CPC-A	Donna Guray-Jurk, CPC-A, CPC-H-A	Hari Reddy, CPC-A	Joshua Felty, CPC-A
Ashley Lynn Quattromani, CPC-A	Christina Mitchell, CPC-A	Donna Jones, CPC-A	Haribabu Kattoji, CPC-A	Julia Heltman, CPC-A
Ashwini Gbate, CPC-A	Christina Williams, CPC-A	Donna L Garamone, CPC-A	Harjati Wibowo, CPC-A	Julia Smith, CPC-A
Avishek Chakraborty, CPC-A, CPC-H-A	Christy M Steele, CPC-A	Donna Lineberger, CPC-H-A	Harold Bautista, CPC-A	Juliana N Whited, CPC-A
Babu Rajadesingh, CPC-A	Cindy McRoberts, CPC-A	Donna Lyn Tice, CPC-A	Heather Watt, CPC-A	Julianne Stout, CPC-A
Bachileo Vijay Baskar, CPC-A	Cindy Ann Andersen, CPC-A	Donna Weyrens, CPC-A	Heather Bock, CPC-A	Julie Dylla, CPC-A
Bai Courtemanche, CPC-A	Claudia Fernandez, CPC-A	Dorina Simpson, CPC-A	Heather Ortiz-Garcia, CPC-A	Julie Kay Francis, CPC-A
Balkees Hashemee, CPC-A	Claudio Garcia, CPC-A	Doris Loftin, CPC-A	Heidi Ann Cantermen, CPC-A	Julie Rose Zausmer, CPC-A
Barbara Bolton, CPC-A	Clay T McGrew, CPC-A	Dorothy Poverelli, CPC-A	Heidi Baddis, CPC-A	Julie Williams, CPC-A
Barbara Christine Painter, CPC-A	Colette Tan-Foster, CPC-A	Dorothy Six, CPC-A	Helena Dorrell, CPC-A	Julene Hooter, CPC-A
Barbara Elizabeth Gallow, CPC-A	Colleen Berg, CPC-A	Dr. Debi Prasad Barik, CPC-A	Hemala Karunakaran, CPC-A	Juliette Erhart, CPC-A
Barbara Gail Blackstone, CPC-A	Connie Myers, CPC-A	Dwight E Dykes, CPC-A	Henry Koehler, CPC-A	June Stook, CPC-A
Barbara Haines, CPC-A	Constance J Vascik, CPC-A	Edie Oliver, CPC-A	Holly Young, CPC-A	Justin Press, CPC-A
Barbara N Abdul Aziz, CPC-A	Corales Thompson, CPC-A	Edith Susan Henson, CPC-A	Huiyan Xiu, CPC-A	Justyna Taha, CPC-A, CPC-H-A
Barry Vogel, CPC-A	Courtney Bethke, CPC-A	Edmond Derderian, CPC-A	Ifigenia Papathomas, CPC-A	Juve Ann Lindberg, CPC-A
Basima Mahmoud, CPC-A, CPC-H-A	Crystal Dawn Ruark, CPC-A	Elena Dichoso Mallhan, CPC-A	Ines Myers, CPC-H-A	Kaisheka J Boyd, CPC-A
Becky Harrington, CPC-A	Crystal Michelle Chandler, CPC-A	Elisa Sanchez, CPC-A	Inez Nixon Prince, CPC-A	Kalyn Reed, CPC-A
Bernadette Batista, CPC-A	Crystal Phillips, CPC-A	Elise Kukuze, CPC-A	Jacqueline Wilson, CPC-A	Kara Secord, CPC-A
Bernadette Del Rosario Cenon, CPC-A	Cynthia A Heunemann, CPC-A	Elise Smith, CPC-A	Jaime Lynn Atkinson, CPC-A	Karen Carmichael, CPC-A
Bess Brown, CPC-A	Cynthia Harding, CPC-A	Elizabeth Busch, CPC-A	Jaimie Sossaman, CPC-A	Karen Citron, CPC-H-A
Beth Ann Doucette, CPC-A	Cynthia Jean Johnson, CPC-A	Elizabeth Carpenter, CPC-A	Jamie Cox, CPC-A	Karen Hood, CPC-A
Beth Merritt, CPC-A			Jamie Lee Stevens, CPC-A	Karen K Hull, CPC-A

Karen Mayer, CPC-A	Leslie Shaeffer, CPC-A	Melanie Joy Tovar, CPC-A	Porschia Lauren Mason, CPC-A	Samiksha Panwar, CPC-A
Karen Sklavos, CPC-A	Leticia Marrero, CPC-A	Melanie M Frees, CPC-A	Praful Nikam, CPC-A	Samuel Burson, CPC-A
Karen Wiehoff-Probst, CPC-A	Letitia Clemons, CPC-A	Melanie Miller, CPC-A	Pranathi Adem, CPC-A	Sandra B Allen, CPC-A
Karen Witzler, CPC-A	Liangyan Hu, CPC-A	Melissa Landreneau, CPC-A	Prasanna Ranganathan, CPC-A	Sandra Marie Gaul, CPC-A
Kari Bonde, CPC-A	Linda Flory, CPC-A	Melissa Lohr, CPC-A	Prashant Patel, CPC-A	Santosh Kumar Bhalle, CPC-A
Karla Rodriguez, CPC-A	Linda Kay Auer, CPC-A	Melissa M Buzza, CPC-A	Prashanthi Kadiyala, CPC-A	Sara Ann Gilmore, CPC-A
Karthick Mohan, CPC-A	Linda Pilz, CPC-A	Melissa M Clough, CPC-A	Prem Reddy, CPC-A	Sara Ann Smith, CPC-A
Karthik Bashetti, CPC-A	Lindsay Janel Stutzman, CPC-A	Melissa Snyder, CPC-A	Priyadharshini Kanakaraj, CPC-A	Sara B Pledoux, CPC-A
Karthika Mundasamy, CPC-A	Lindsey Dawes, CPC-A	Melissa Williams, CPC-A , CEMC	Puspa Sahoo, CPC-A	Sara Hewitt, CPC-A
Kathie Espinoza, CPC-A	Lisa Ahrens, CPC-A	Melody Buenavides, CPC-A	Rachel Stufflebeam, CPC-A	Sara Runyon, CPC-A
Kathleen Cooper, CPC-A	Lisa Bufford, CPC-A	Melody K Cole, CPC-A	Rajalakshmi R, CPC-A	Sara Wristen, CPC-A
Kathleen F Llanes, CPC-A	Lisa Nicole Phillips, CPC-A	Michael Bowning, CPC-A	Rajihna Dean Ismail, CPC-A	Sarah Campos, CPC-A
Kathleen Lotz, CPC-A	Lisa Ann Bauer, CPC-A	Michael Coddington, CPC-A	Ramkumar Kuppusamy Sivasankaran, CPC-A	Sarah Holcomb, CPC-A
Kathrain O'Keefe, CPC-A	Lisa Hawley, CPC-HA	Michael Dick, CPC-A	Ramon Limon, Jr., CPC-A	Sarah Labrec, CPC-A
Kathryn H Walker, CPC-A	Lisa Marie Dean, CPC-A	Michele Anderson, CPC-A	Randi Uelman, CPC-A	Sarah Sherouse, CPC-A
Kathy Forgacs, CPC-A	Lisa Scanlon, CPC-HA	Michele Josette Spells, CPC-A	Raviraja Nagula, CPC-A	Sarah Stanley, CPC-A
Kathy Lower, CPC-A	Lisa Sharp, CPC-A	Michele Mathewson, CPC-A	Raymond Adams, CPC-A	Saravanan Palsamy, CPC-A
Katie Purpur, CPC-A	Lisa Vandelac, CPC-A	Michelle Rogers, CPC-A	Rebecca Bennett, CPC-A	Saravanan Sathyanathan, CPC-A , CPC-HA
Katrina Marie Young, CPC-A	Liz Huemmer, CPC-A	Michelle Sylvestre, CPC-A	Rebecca Blum, CPC-A	Saritha Samuthiram, CPC-A
Katrina Szela, CPC-A	Liza McLucas, CPC-A	Michelle Cottle, CPC-A	Rebecca Danner, CPC-A	Sathyagiriya Seethapathy, CPC-A
Kavitha Bhatia, CPC-A	Lois Hartman, CPC-A	Michelle Felarca, CPC-HA	Rebecca E Keen, CPC-A	Scott Burton, CPC-A
Kayla Gourgues, CPC-A	Lois Katherine Cox, CPC-A	Michelle Hoffman, CPC-A	Rebecca Pursley, CPC-A	Shala D Markley, CPC-A
Keela Philippe, CPC-A	Lola Head, CPC-A	Michelle Johnson, CPC-A	Rebecca S Killion, CPC-A	Shalini Thirunavukkarasu, CPC-A
Kelleigh Nicole Rhone, CPC-A	Loordu Mary Arul Mariya Nadhan, CPC-A	Michelle Laird, CPC-PA	Rebecca Sullivan, CPC-A	Shanece Douglas, CPC-A
Kelley Gantt, CPC-A	Loraine Teffeteller, CPC-HA	Michelle Mariano Anil, CPC-A	Rebecca Thompson, CPC-A	Shanmugeswaran Matheswaran, CPC-A
Kelli Hooper, CPC-A	Lori Arena, CPC-HA	Mindy Rice, CPC-A	Reddi Prasanna Nagineni, CPC-A	Shannon Coleman, CPC-A
Kelly Sanchez, CPC-HA	Lori Brethel, CPC-A	Misty Hodges, CPC-A	Regen Place, CPC-A	Shannon Hubble, CPC-A
Kelly Schadt, CPC-A	Lori C Roberts, CPC-A	Misty Jenkins, CPC-A	Regina Hardymon, CPC-A	Sharaa M Xiong, CPC-A
Kemmerly D Humphreys, CPC-A	Lori Carlton, CPC-A	Mohanasundari Dayalan, CPC-A , CPC-HA	Regina Lee Nowakowski, CPC-HA	Sharon Michelle Appel, CPC-A
Kerri Brooks, CPC-A	Lorraine Spicker, CPC-A	Mollie D Miller, CPC-A	Regina Solorio, CPC-A	Sharon Rubert, CPC-A
Kevin Karolan, CPC-A	Lucy Narciso, CPC-A	Monica Thornton, CPC-A	Rei Sugaya, CPC-A	Sheena Crisostomo, CPC-A
Kevin Pursel, CPC-A	Lynda Brown, CPC-A	Monika Kantawala, CPC-A	Renata Wojciechowski, CPC-A	Sheena Maria Bambus, CPC-A
Kim Dunn, CPC-A	Lyndall Naumann, CPC-A	Morgan Tondike, CPC-A	Renee Bushmaker, CPC-A	Sheila Bishop, CPC-A
Kim Picchiarini, CPC-A	Lynn Hillyard, CPC-A	Muneeswaran Karuppasamy, CPC-HA	Richard Whited, CPC-A	Sheila Michelle Nin, CPC-A
Kim Shelton, CPC-HA	Lynne Smith, CPC-A	Nancy Horta, CPC-A	Richel Laughy, CPC-A	Sheila Moseley, CPC-A
Kim Terhurne, CPC-A	Ma. Bianca Castillo, CPC-A	Nancy Yang, CPC-A	Rita Reiman, CPC-A	Shelby Davis, CPC-A
Kim Waugh, CPC-A	Ma. Concepcion Ducut, CPC-A	Narashiman Ramamoorthy, CPC-A , CPC-HA	Robeena Ansari, CPC-A	Shelena Williams, CPC-A
Kimberly Frances Villegas, CPC-A	Ma. Marisse Cruz Garcia, CPC-A	Naresh Dumpeti, CPC-A	Robert Mandeville, CPC-A	Shella Minnick, CPC-A
Kimberly Klee, CPC-A	Madhura Rao, CPC-A	Natalie Eisenhower, CPC-A	Robert Abbondanzio, CPC-HA	Shelle Miller, CPC-A
Kimberly Sue Downs, CPC-A	Madison M Berchtold, CPC-A	Natalie Lafranchi, CPC-A	Robert Joemarie Alinsog, CPC-A	Shelly Pehlgim, CPC-A
Kimberly Walter, CPC-A	Magan Collins, CPC-A	Natalie Landwehr, CPC-A	Robert Reevesman, CPC-A	Sheri Krutson, CPC-A
Kimberly Wicker, CPC-A	Magelin Paredes, CPC-A	Natalie Naylor, CPC-A	Robin Jenice Bartolomeo, CPC-A	Sheri Davison Harris, CPC-A
Kiona McDougald, CPC-A	Manikantan Olagappan, CPC-A	Nathalie Marie Ward, CPC-A	Robin Sellers, CPC-A	Sherrie C Aguilar, CPC-A
Kiran Kumar Saripalli, CPC-A	Manjupriya Kannan, CPC-A , CPC-HA	Naveen Kumar Mekala, CPC-A	Robin Stovall, CPC-A	Shirley Allore, CPC-A
Kori Sawyer, CPC-A	Marcia Herstein, CPC-A	Nehal Kulawade, CPC-A	Rochelle J Wolff, CPC-A	Shine Lawrence, CPC-A
Kortnee Saccoman, CPC-A	Marcy Lynn Linke, CPC-A , CPC-HA	Nellie A Stephensen, CPC-A	Rochelle Marty Bacani, CPC-A	Shona Morrison, CPC-A
Krischauna Birmler, CPC-A	Margaret Perry, CPC-A	Nicole Read, CPC-HA	Rochelle Padilbar DeOcampo, CPC-A	Shyamala Devi, CPC-A
Krishna Surapanini, CPC-A	Margaret Wilkinson, CPC-A	Nicole St Marie, CPC-A	Roger Comer, CPC-A	Sean Sutar, CPC-A
Kristen Coombs, CPC-A	Maria Hernandez, CPC-A	Nicole Tye, CPC-A	Roger Rangai, CPC-A	Sindy Lentini, CPC-A
Kristen Johnson, CPC-A	Maria R Garcia, CPC-A	Nicolo Antiporda, CPC-A	Ronda Robinson, CPC-A	Slvakumar Sathishkumar, CPC-HA
Kristen Obarski, CPC-HA	Maria Tatman, CPC-A	Nikquita Dukes, CPC-A	Rosario Gudino, CPC-A	Sneha Gadewar, CPC-A
Kristi Lucht, CPC-A	Maribel Villa, CPC-A	Nina Marie Bryant, CPC-A	Rose Hack, CPC-A	Sofia Love, CPC-A
Kristin J Frost, CPC-A	Marina Ammirato, CPC-A	Nina Ron, CPC-A	Rose Kovar, CPC-A	Sonali Jagtap, CPC-A
Kristine Cannon, CPC-A	Marrie Cris Ariaga, CPC-A	Ninette Vera Jones, CPC-A	Rose Skuppin, CPC-A	Sonja Devenney, CPC-A
Kristine Davison, CPC-A	Mary Douglas, CPC-A	Nithish Bhuvanendran, CPC-A	Roseann Volpi, CPC-A	Sonya Cardenas Vidales, CPC-A
Lacey Ann Dinh, CPC-A	Mary Elizabeth Rassel, CPC-A	Nundkieswaringsh Bossoondyal, CPC-A	Rosemarie Morgan, CPC-A	Sonya Fuller, CPC-A
Lacy Hudgens, CPC-A	Mary Bilello, CPC-A	Olimpia Queiros Jacques, CPC-A	Rosemary Castro, CPC-A	Sophia Boylen, CPC-A
Lakita House, CPC-A	Mary C Clements, CPC-A	Pam Penick, CPC-A	Rosemary M Mercier, CPC-A	Sridevi Parvathaneni, CPC-A
Lara Applegate, CPC-A	Mary Cercone, CPC-A	Pamela A Turosky, CPC-A	Rowena Bajet, CPC-A	Srinanth Chakravarthy Pyarasan, CPC-A
Latasha Nicole Biggers, CPC-A	Mary Constance Tiralla, CPC-A	Pamela Garrett, CPC-A	Roxane Thompson, CPC-A	Srinivas Vaka, CPC-A
Laura James, CPC-A	Mary Elizabeth Honeycutt, CPC-A	Pamela Jean Hummel, CPC-A	Roxanne G Robles, CPC-A	Stacey Marie Helleloid, CPC-A
Laura Mowry, CPC-A	Mary Ellen Grom, CPC-A	Pamela Kirkwood, CPC-A	Rubini Nancy, CPC-A	Staci Morrow, CPC-A
Laura Mueller, CPC-A	Mary Hall, CPC-A	Paryus Patel, CPC-A	Ruth Winingar, CPC-A	Stacy Bellamy, CPC-A
Lauren Byron, CPC-A	Mary Russell, CPC-A	Patrice Lemon, CPC-A	S Shobha Rani, CPC-A	Stacy Lynn Van Tassel, CPC-A
Lauren Elizabeth Allen, CPC-A	Mary S Magpayo, CPC-A	Patricia Peterson, CPC-A	Sabrina Anderson, CPC-A	Stefanie Carroll, CPC-A
Lauren Knox, CPC-A	Marybeth Horne, CPC-A	Patricia Ponturo, CPC-A	Sahaya Sonia Soosaiah, CPC-A	Stella Baker, CPC-A
Laurie Cripe, CPC-A	MaryJane Elizabeth Kelley, CPC-A	Patricia Sagvold, CPC-A	Sallee Miller, CPC-A	Stephanie Cloninger, CPC-A
Laurie Mullen, CPC-A	Matt Parnes, CPC-A	Patricia Sharon Brown, CPC-A	Sallie Anderson, CPC-A	Stephanie Marie Gugliotti, CPC-A
Lavanya Domala, CPC-A	Mattie Daley, CPC-A	Paula Chesnut, CPC-A	Sally Blackie, CPC-A	Stephanie Michelle Barisa, CPC-A
Lay L Zaw, CPC-A	Medessa Kirby, CPC-A	Penny Lee Bault, CPC-A	Sally Deeds, CPC-A	Steve Bales, CPC-A
Leah Wall, CPC-A	Meera CM, CPC-HA	Penny Spaulding, CPC-A	Sam Nuthalapaty, CPC-A	Sunny Bhatia, CPC-A
Lesley Bietz, CPC-A	Megan Gillette, CPC-A	Phylondria Williams, CPC-A	Sam Shoukair, CPC-A	Supriya Devanu, CPC-A

Suresh Kumar Sankenapura Mayanna, **CPC-A**Susan Achard, **CPC-A**Susan Coleman, **CPC-A**Susan Gray, **CPC-A**Susan Mecodangelo, **CPC-A**Susan Moore, **CPC-A**Susan Peters White, **CPC-A**Susan Zarbo, **CPC-A**Susana Gonzalez, **CPC-A**Susithra Ganesan, **CPC-A**Suzanne Strobbe, **CPC-A**Sylvia Hale, **CPC-A**Sylvia Maldonado, **CPC-A**Talitha Mitchell, **CPC-A**Tamara Edmonds, **CPC-A**Tamberlyn Green, **CPC-A**Tamri Friel, **CPC-A**Tamri Neiger, **CPC-A**Tamilselvi Venkatesan, **CPC-HA**Tammy Snyder, **CPC-A**Tammy Eisentrout, **CPC-A**Tamra Jean Dirksen, **CPC-A**Tanya Briand, **CPC-A, CPC-HA**Tanya Lopes-Rodrigues, **CPC-A**Tarik Ibrahim, **CPC-A**Taronza Ellison, **CPC-A**Tasha Johnson, **CPC-A**Tatsiana Adamik, **CPC-A**Tera Tawanna Clark, **CPC-A**Teresa Unkefer, **CPC-A**Teresa Brewer, **CPC-A**Teresa Hodges, **CPC-A**Teresa Hosea, **CPC-A**Teresa Poling, **CPC-A**Teresa Smith, **CPC-A**Teresa Tomtishen, **CPC-A**Teresa Weaver, **CPC-HA**Terri Capozzo, **CPC-A**Terri G Charpentier, **CPC-A**Tessa Castagno, **CPC-A**Tessa Davis, **CPC-A**Tessie Rose Silbaugh, **CPC-A**Theresa Dunnington, **CPC-A**Theresa Holford, **CPC-A**Theresa Sabatini, **CPC-A**Tiffani Jonne Davis, **CPC-A**Tiffany Heimbuch, **CPC-A**Tiffany Beaulieu, **CPC-A**Tiffany Danielle Hampton, **CPC-A**Tiffany Graves, **CPC-A**Tiffany Maglish, **CPC-A**Tiffany Thomas, **CPC-A**Tina Hitchner, **CPC-A**Tina Lorraine Hoppie, **CPC-A**Tina Sumiko Lounsbury, **CPC-HA**Tina Swenson, **CPC-HA**Tobie Forte, **CPC-A**Toni Fahrenkamp, **CPC-A**Tonya Horne, **CPC-A**Tonya M Covington, **CPC-A**Traci Strachota, **CPC-A**Tricia Elizabeth Smith, **CPC-A**Trisha Nardi, **CPC-A**Tyrah Jerideau, **CPC-A**Valerie Blackford, **CPC-A**Valerie C Fisher, **CPC-A**Valerie Mengis, **CPC-A**Vandetta Mongeau, **CPC-A**Vanesa Duarte, **CPC-A**Venkat Raghavan, **CPC-A**Vernita Haynes, **CPC-A**Vicki Spears, **CPC-A**Vickie White, **CPC-A**Vicky Diane Mansur, **CPC-A**Vidhya Rajaraman, **CPC-A**Viengkham Sundara, **CPC-A**Vijay Bonagiri, **CPC-A**Vijayarajkumar Banuchandar, **CPC-A**Vineesh Mathew Thomas, **CPC-A**Vishalkumar Adeshara, **CPC-A**Vivian C Darden, **CPC-A**Wanda Currie, **CPC-A**Wendy Hornyak, **CPC-A**Wendy Myers, **CPC-A**Wendy Rangel, **CPC-A**Wendy Sells, **CPC-A**Wendy Vuyk, **CPC-A**William J Odackal, **CPC-A**William Phillips, **CPC-HA**Wilma Villalobos Razon, **CPC-A**Yalda R Attig, **CPC-A**Yanhong Hou, **CPC-A**Yufu Ou, **CPC-A**Zaid J McCoy, **CPC-A**Zuhair Yahya, **CPC-A**

Specialties

Alison Parker, **CGIC**Alka Jhurani, **CCC**Allison Blythe, **CPC, CCC**Amber Condren, **CPC, CEMC**Amy Darden Broussard, **CPC, CPPM**Amy McCormick, **CPC, CGSC**Andrea Hochstatter, **CPC, CEDC**Andrea R Winfield, **CPC, CCC**Angela Short, **CPCO, CPCD**Anita Robinson, **CPC, CPC-H, CPC-P, CPMA**Ann Marie Bianca, **CPPM**Ann Silvia, **CPC, CPMA, CPC-I, CANPC, CEMC, CFPC**Anna L Harris, **CPC, CPCO**Bonnie Wright, **CEDC**Brandy DeAnn Sherrer, **CPC, CEMC**Carla Ann Wallace, **CPC, CFPC, CPEDC**Carla Detaranton, **CPC, CPMA**Carol Leann Hamerski, **CPC, CPCO**Christine M Jolitz, **CPC, CEMC, CFPC**Cindy L Miller, **CPC, CPMA**Colleen Hill, **CPC, CPPM**Cristina A Duthie, **CPC, CPMA**Cynthia Lyssy, **CPC-A, CPMA**Danelle Lynn Olson, **CPC, CPMA**Danielle Odonohue, **CPC, CPMA**David Silva Mojica, **CPPM**Deann Tate, **CPC, CPMA, CCC, CEMC**Deanna Loree Riedel, **CPC, CEMC**Debbie Bound, **CPC, CPC-I, CEMC**Deborah Gaspari, **CPC, CEMC**Debra L Kenney, **CPC, CPMA**Diane M Lane, **CPC, CCC**Donna Marie Lynch, **CPC, CPMA**Emoy E Goodridge, **CPC, CPC-H, CPMA, CPC-I**Eric R Schueler, **CPC, CEMC**Gema Balbin-Rodriguez, **CPMA**Gina Patricia Holdorff, **CPC, CPC-H, CPCO, CPC-P, CPMA, CHONC**Gloria J Wason, **CPC, CPMA, CEMC**Haojie Jessica Hu, **CPC, CPC-H, CPMA**Indira Jimenez, **CPC-A, CPMA**Jacob Swartzwelder, **CPC, CEMC**Jamie Mayes, **CANPC**Janet S Williams, **CPC, CCC**Janine Eigenbrode, **CPPM**Jennifer McPolin, **CPC, CPMA**Jennifer Michelle Kastner, **CPC, CPMA, CEMC**Jennifer Nellums, **CIRCC**Jennifer Rae Wilson, **CPC, CPCO, CEMC**Jill Serfass, **CANPC**Jill Roeting, **CPC, CEMC**Joan Lemaire, **CPC, CGIC**Johnna Floyd, **CPC, CPMA**Julian Summers, **CPCD**Julie Wilson, **CPMA, CGSC, COBGC, COSC**Kadie Gibson-Karanikas, **CPC, CPPM, CCVTC**Karen Pike, **CPC, CPCO**Katherine C Rudolewicz, **CPC, CGIC**Kathleen A Bailey, **CPC, CPMA**Kelly King, **CPC, CEMC**Kim Gordon, **CPC, CPCD, CUC**Kimberly Marie Sullivan, **CPC, CEMC**Kristi Mathews, **CGIC**Kristy O'Bryan, **CIRCC**LaShonda Denise Hannah, **CPC, CGSC**Lauren Flannery, **CPC, CCC**Laurie S McGaffey, **CPC, CPMA**Lena Gail Holbrook, **CPC, CPMA, CCVTC, CEMC**Leonie Natasha Gilzeane, **CPC, CPMA**Leslie Huck, **CPC, CPCO, CPC-P, CPMA, CEMC**Linda Benner, **CPC, CPMA, CASCC, COBGC**Linda Diane Evans, **CPC, CGSC**Lorraine Nelson, **CIRCC**Lorrie Soffes, **CASCC**Louise Slack, **CPC, CPMA**Lucita Francisco Vartanian, **CPC, CIRCC, CPMA**LuGina Sue Stephens, **CPC, CPPM, CPC-I**Margaret S Dupont, **CPC, CPMA**Maria D Nunez, **CPC, CPMA**Marie Ferlito, **CPC, CEMC**Marilyn Maierhofer, **COSC**Mark S Block, **CSFAC**Mary Celeste Eisele, **CPC, CIRCC, CPMA**Mary Christine Ladzinski, **CPC, CCC**Mary Jo Coen, **CPC, CEMC**Mary Margaret Moore, **CPC, CCC**Mary Michelle Watkins, **CPC, CCC**Maybelle Encarnado, **CPC, CPCO**Maylene Felicia Rivero, **CPC, CPMA**Melanie Dawn Rideout, **CPC, CPC-H, CPMA, CPC-I**Melissa Donnahoe, **CPC, CPMA**Melissa Wright, **CANPC**Michele I Walker, **CPC, CPMA**Michelle Marie Wood, **CPC, CEMC**Mileidy Cobo, **CPC, CPMA**Nancy Daoust, **CPC, CCVTC**Nayle Durruthy, **CPC-A, CPMA**Ola Boland, **CPC, CEMC**Omega Renne, **CPC, CEMC, CIMC**Paige Flaherty, **CPC, CPMA**Pamela J Hardy, **CPC, CPPM**Pamela Jean Zulauf, **CPC-A, CASCC**Patricia A Bailey, **CPC, CANPC**Patricia Marini, **CPC, CEDC**Paul Jason Chandler, **CPC, CPCO, CPMA**Paulette Karelitz, **CGIC**Penka Dringova, **CPC, CPMA, CEMC, CGIC, CGSC, CIMC**Peter J O'Toole, **CPC, CEDC**Priti Dayal, **CPC, CEMC, COBGC**Raquel Lillie Duran, **CPC, CEMC**Rhonda L Fletcher, **CPC, CPMA, CEMC, CENTC, CFPC**Richelle Brown, **CPC, CPEDC**Sandra Boyd, **CPC, CCC**Sandra D Hill, **CPC, CEDC**Sandra Pedersen, **CPC, CPMA, CEMC**Santa Allaire, **CPC, CIRCC, CEMC**Sharon A Stone, **CPC, COSC**Shawndenne Lomax-Mosley, **CPC, CPMA**Sherry Rose Naldrett, **CPCO, CPMA**Shirley Harris, **CPC, CPMA, CEMC**Silvia Rosado, **CPC, CPMA**Stephanie Hutson, **CPC, COBGC**Stephanie May Sjogren, **CPC, CPMA**Susan Needham, **CPC, CEMC**Tamra H McLain, **CPC, CPC-H, CEMC**Terri Ann Feece, **CPC, CPMA**Terri Anne Gribbon, **CPC, CPMA**Tessa Hanson, **CIRCC**Tina Marie Gaworecki-Galler, **CPC, CPPM**Tracy Zurbuchen, **CPC, CPEDC**Trisha Jacobson, **CPC, CPCD**Valerie Henderson, **CPCD**Vanessa Dawn Coles RHIT, **CPC, CPMA, CEMC**Victoria Gould, **CIRCC**

Magna Cum Laude

Amy D Brown, **CPC**Amy Wildenberg, **CPC-A**Barbara K Bennett-Evans, **CPC-H**Cheryl A MacLeod, **CPC-A**Cynthia Hathaway, **CPC-A**Debra L Rotteck, **CPC-A**Dennie L Floda-Smith, **CPC, CASCC**Diane Gunn, **CPC-A**Diane Krueger, **CPC-A**Diane Zsofka, **CPC-A**Donna Richardson, **CPC-A**Elizabeth Allen, **CPC**Erin Ann Jouswma, **CPC**Gayle Miller, **CPC-A**Graciela Colombani, **CPC**Heather Guertin, **CPC-A**Jorge L Cabrera Villavicencio, **CPC**Joshua Dalton, **CPC-A**Julie J Jones, **CPC**Karen L Schumacher, **CPC-A**Kathryn Boomsma, **CPC-A**Laurie Johnson, **CPC**Malgorzata Lubinska, **CPC-A**Marie Knoblock, **CPC-A**Megan Anderson, **CPC-A**Michele Maisey, **CPC-A**Nikki M Joyner, **CPC-A**Pamela J Linton, **CPC, CANPC**Raquel Lindal, **CPC-A**Sarah Sigmon, **CPC-A**Shawn Christopher, **CPC-A**Stacy Lynn Shaw, **CPC**Stephanie Wells, **CPC-A**Susan Sellers, **CPC-A**Susan Zakraysek, **CPC-A**Tammy Bartosz, **CPC**Tawnya Garrett, **CPC-A**Vinitha Vijayan, **CPC-A**

A&P Quiz Answer

The correct answer is D. A loss of blood circulation to an appendage could result in skin ulcers or gangrene, which could ultimately lead to amputation.



DECEMBER WORKSHOP



2013 CPT® CODING UPDATES

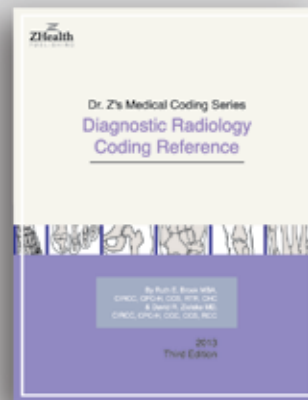
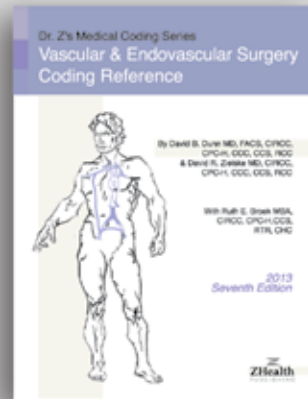
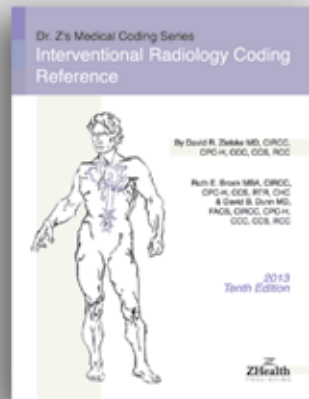
Up to 6 CEUs | \$149.95 | Author: Raemarie Jimenez, CPC, CPMA, CPC-I, CRHC

Co-Author: G. John Verhovshek, CPC

Don't miss out on your final chance to register for this December event. Our half-day workshop available in 40+ cities will provide you with in-depth instruction and hands-on application of the coming changes. Can't attend live? Get on-demand access to our workshop by visiting our website.

Date	Location	Date	Location
Sat, Dec. 1	Anchorage, Alaska	Wed, Dec. 5	Pasadena, California
Sat, Dec. 1	Fort Lauderdale, Florida	Wed, Dec. 5	Philadelphia, Pennsylvania
Sat, Dec. 1	Grand Rapids, Michigan	Wed, Dec. 5	Salt Lake City, Utah
Sat, Dec. 1	Indianapolis, Indiana	Wed, Dec. 5	San Diego, California
Sat, Dec. 1	San Francisco, California	Wed, Dec. 5	Seattle, Washington
Tues, Dec. 4	Chicago, Illinois	Wed, Dec. 5	St. Louis, Missouri
Tues, Dec. 4	Cleveland, Ohio	Wed, Dec. 5	Tampa, Florida
Wed, Dec. 5	Atlanta, Georgia	Wed, Dec. 5	Tulsa, Oklahoma
Wed, Dec. 5	Baltimore, Maryland	Thurs, Dec. 6	Phoenix, Arizona
Wed, Dec. 5	Boston, Massachusetts	Fri, Dec. 7	Detroit, Michigan
Wed, Dec. 5	Charlotte, North Carolina	Fri, Dec. 7	Birmingham, Alabama
Wed, Dec. 5	Columbus, Ohio	Fri, Dec. 7	Houston, Texas
Wed, Dec. 5	Dallas, Texas	Fri, Dec. 7	Kansas City, Missouri
Wed, Dec. 5	Denver, Colorado	Fri, Dec. 7	Lexington, Kentucky
Wed, Dec. 5	Hartford, Connecticut	Fri, Dec. 7	Long Beach, California
Wed, Dec. 5	Jacksonville, Florida	Fri, Dec. 7	New Orleans, Louisiana
Wed, Dec. 5	Louisville, Kentucky	Fri, Dec. 7	Pittsburgh, Pennsylvania
Wed, Dec. 5	Milwaukee, Wisconsin	Fri, Dec. 7	Tucson, Arizona
Wed, Dec. 5	Morristown, New Jersey	Sat, Dec. 8	Albuquerque, New Mexico
Wed, Dec. 5	New York, New York	Sat, Dec. 8	Nashville, Tennessee
Wed, Dec. 5	Norfolk, Virginia	Sat, Dec. 8	Portland, Oregon
Wed, Dec. 5	Omaha, Nebraska	Sat, Dec. 8	Raleigh, North Carolina
Wed, Dec. 5	Orlando, Florida		

Find a workshop location near you and register today at: www.aapc.com/2013cpt | 1-800-626-CODE (2633)



2013 BOOKS NOW AVAILABLE

- Interventional Radiology Coding Reference
- Vascular & Endovascular Surgery Coding Reference
- Diagnostic & Interventional Cardiovascular Coding Reference
- Diagnostic Radiology Coding Reference
- CIRCC Study Guide 2013

- Webinar: December 4, 2012
Noon CST covering the New 2013 Updates
- Seminar: February 19-22, 2013
Firesky Resort & Spa, Scottsdale, AZ
visit ZHealthPublishing.com or call 1-877-873-9893

"2013 brings the most significant change to Cardiology and Interventional Radiology coding since I started publishing my coding references. Numerous code changes and new bundling guidelines will require added focus to remain in compliance." - Dr. Z

2013 WEBINAR SUBSCRIPTIONS

The Best CEU Value On The Planet

*Entire office can attend from Jan. 1, 2013 through Dec. 31, 2013

CODING/ BILLING

Approved for 20+ Certifications

- 40+ coding/billing webinars for 2013 (Live or On Demand)
- 40+ coding/billing webinars for 2012 (On Demand)
- Two (2) CEUs per webinar, per attendee (80+ CEUs for 2013 alone)
- **Bonus:** 2014 CPT® Updates Included

~~\$795~~
\$745
Through Dec. 31st

New
for 2013

In order to support our expanding credentials for the business of health care, we are now offering exclusive webinar subscriptions for the following credentials which are not included in the coding/billing subscription:

COMPLIANCE

CPCO™

Approved

- Six (6) compliance webinars for 2013 (Live or On Demand)
- Two (2) CEUs per webinar, per attendee (12 CEUs)

\$249

AUDITING

CPMA®

Approved

- Six (6) auditing webinars for 2013 (Live or On Demand)
- Two (2) CEUs per webinar, per attendee (12 CEUs)

\$249

PRACTICE MANAGEMENT

CPPM®

Approved

- Six (6) practice management webinars for 2013 (Live or On Demand)
- Two (2) CEUs per webinar, per attendee (12 CEUs)

\$249

CPT® is a registered trademark of the American Medical Association

*Webinars are for personal or single-office (e.g. a conference room) use only and may not be rebroadcast, retransmitted, shared or disseminated. In addition, AAPC local chapters or other groups of individuals representing multiple companies or separate offices within a single facility do not constitute a "single-office" and may not share a single event or subscription webinar license. A computer with a high speed Internet connection and speakers (or headphones) is recommended to connect to the event. Subscriptions are valid January 1- December 31, 2013.

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

