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5th Annual Auditing Conference 2013

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- The ONLY National Auditing Specific Conference
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From Antepartum to Postpartum, Get the CPT® OB Basics
Dawson Ballard, Jr., CPC, CEMC, CCS-P
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On the Cover: From antepartum to postpartum care, Dawson Ballard, Jr., CPC, CEMC, CCS-P, explains obstetric coding basics and what’s included in the global obstetrics package. Cover design by Tina Smith.
This 4-hour hands-on workshop will uncover the secrets of documentation review to identify the most common errors plaguing your practice (resulting in frequent denials and increased compliance risks). We’ll then reveal the key steps to ensure proper documentation, compliant coding, and correct billing, as well as the impact on reimbursement if any of these are not done correctly.

- Identify the 10 most commonly missed billable charges
- Append modifiers to assure appropriate reimbursement
- Apply payment policies to support medical necessity
- Recognize the top 10 documentation deficiencies that impact compliance and reimbursement
- Communicate missed revenue opportunities to your provider
- Review both the billing charges and documentation to ensure all billable charges are picked up
- Study real documentation and coding scenarios with open discussion on the proper way of handling denials
- Determine the reimbursement impact for coding and billing errors
- Examine claim information prior to submission to ensure accuracy

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WORK LEARN ENJOY WORK LEARN ENJOY

Dr. Z’s is the only seminar that I want to be sent to. I always take away a lot of quality information.
-- Chris Moore

I learned so much, I was challenged- the past few days were intense and worth every minute.
-- Patricia Feher

WORK LEARN ENJOY WORK LEARN ENJOY

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Coming Soon
Teamwork Is Necessary, More Than Ever

Sadly, this is the second time in a row I have opened my letter recounting a tragedy. This is not the way I want to start my message, but the events of Moore, Okla., bear mentioning. This is a means to express our thoughts and prayers to and for the people who live in Moore, and to come away from what was a major tragedy with something positive.

Understand the Destruction

To gain some perspective on what happened in Moore, it’s important to understand a few things about storms and tornados. Few people realize it, but scientists tell us, of all the natural maladies in nature, a tornado is the most violent. Winds of an EF5 can reach as high as 300 miles per hour. The one that touched down in Moore was clocked at 210 mph. Experts say it’s extremely rare for a tornado to stay on the ground for more than a few minutes. The Moore tornado stayed on the ground for more than 50 minutes, clear-cutting a more-than-two-mile-wide swath 17 miles long, killing 24 people, nine of whom were children. The tornado erased everything in its path. With the passage of time and community support, I hope our members who have been affected by the events in Moore are able to work through this catastrophe and other events that challenge the spirit. Looking back on it, what impressed me most about the Moore tragedy was the immediate outpouring of help and support. From governmental assistance to relief organizations, I saw America do what it does best. Those who could not be there in person responded with donations of money, supplies, and even blood. It was individuals coming together in the initial stages of the tragedy that played such a crucial role in getting Moore on the road to recovery.

It Takes a Village

In an interview with one of the relief workers the question was asked, “What will it take to bring Moore back?” His answer was, “… a village.” In other words, they were not just repairing what had happened, they were starting over.

That answer intrigued me. “It takes a village” has become a catchphrase in recent times. It means many different hands, with many different skills, are necessary to achieve a common goal. One aspect of “it takes a village” is even more pronounced, more salient; that is, everyone in the village must have one focus.

Focus as a Team in Healthcare

As a surgeon in the operating room, I experienced the “it takes a village” concept firsthand. It takes many different people in the operating room to perform a successful operation. Although individual skills are critical to be truly successful, everyone must be focused on one thing: the patient.

Likewise, getting a medical bill paid right involves much more than just correct coding. Similar to the surgical operation, there are many different touch points within the billing cycle that can effect or even change the final bill. Without a focus on the end result, what goes out the door may be far different than what was intended. Although making the end result the primary focus is a different way of thinking, it can have a significant impact on what is reimbursed and how it’s reimbursed.

The medical industry has evolved in such a way that one person can no longer do it all. The hard truth is we need each other. In our daily lives, just like in the city of Moore, it takes a team and it takes a village. And the great thing about being part of a team or village is … you are never alone.

David B. Dunn, MD, FACS, CIRCC, CCVTC, CPC-H, CCC, CCS, RCC
President, National Advisory Board
Keep Current when Reporting PT G Codes

I found Lynn S. Berry’s, PT, CPC, article “PTs Rise to 2013 G Code Challenge,” in the March edition very helpful. But in implementing it, I noticed a wrong code and an omitted code. In the article, Berry says to use G9157 Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy, but this code isn’t listed in MLN Matters® MM8166 from the Centers for Medicare & Medicaid Services (CMS). Additionally, MM8166 says to use G9186 Motor speech functional limitation, projected goal status at initial therapy, but Berry doesn’t list that code in her article.

Joseph Perrino, MBA

Our apologies. CMS replaced G9157 with G9186 after the March issue was sent to the printer. You will find the most up-to-date information in the Medicare Claims Processing Manual, chapter 5.

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“Neither the 1995 nor 1997 Documentation Guidelines for Evaluation and Management Services state that you cannot count a single item in both the history and ROS. Nothing in the American Medical Association (AMA) or national Medicare guidelines says so either. And the man who is mistakenly credited with having said it was so [Barton C. McCann, MD, executive medical officer of the Health Care Finance Administration (precursor to the Centers for Medicare & Medicaid Services)] has publicly stated that it isn’t. Any payer or auditor who continues to insist on the validity of the ‘double dip urban myth’ ought to know better, and should be challenged.”

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PECOS Errors Threaten Medicare Participation

In 2010, more than half of enrollment records in the Provider Enrollment, Chain and Ownership System (PECOS) were inaccurate, and nearly half of all records in the National Plan and Provider Enumeration (NPPES) contained errors, according to an Office of Inspector General (OIG) May 2013 report ([https://oig.hhs.gov/oei/reports/oei-07-09-00440.pdf](https://oig.hhs.gov/oei/reports/oei-07-09-00440.pdf)).

Wrong mailing and practice addresses were found to be the biggest problem, but incorrect telephone numbers, birth dates, last names, credentials, and licensing information threatened the accuracy of the database, as well.

The Centers for Medicare & Medicaid Services (CMS) uses PECOS to approve provider and supplier participation in Medicare; and physicians use NPPES to obtain national provider identifiers (NPI). Inaccurate information in PECOS can lead to various problems—namely, deactivation of a provider’s Medicare enrollment status if the provider doesn’t receive his or her revalidation notice in the mail.

CMS began its revalidation effort in 2010 to address the known inaccuracies in PECOS. Mistakes in PECOS will carry over to Medicare’s Physician Compare website, which beneficiaries use to locate a physician. Physicians can correct their information on the Physician Compare website by revising their PECOS records.

CMS Corrects Laboratory Specimen Collection Code

CMS issued a transmittal June 20 to correct the coding requirements for specimen collection in the Medicare Claims Processing Manual (chapter 16, section 60.1.4). Effective July 16, 2013, labs are instructed to use the following codes to report routine venipuncture for collection of specimen(s):

- **36415** Collection of venous blood by venipuncture
- **P9615** Catheterization for collection of specimen(s)

Policy and claims processing remains the same. System or laboratory fee schedule updates are unnecessary because the fee schedules and systems were updated with the code change.


Coverage for OPT with Verteporfin Expands

CMS has expanded coverage for ocular photodynamic therapy (OPT) with verteporfin for macular degeneration. Coverage of OPT with verteporfin for “wet” age-related macular edema includes codes:

- **67221** Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)
- **+67225** Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment)

According to *MLN Matters*® MM8292, “CMS is revising the requirements for testing to permit either Optical Coherence Tomography (OCT) or Fluorescein Angiogram (FA) to assess treatment response. All other coverage criteria would continue to apply.” The implementation date is July 16, 2013, with an effective date of April 3, 2013. Claims will not be retroactively adjusted from April 3, 2013 unless a claim is brought to the Medicare contractor’s attention.


Speak Up and Be Heard!

Do you have a question regarding information found in *AAPP Cutting Edge*? Or maybe you have a difference in opinion you would like to share with your peers? Write us at letterstotheditor@aapc.com.
Lost CEUs:
It Could Happen to You!

Safeguard your certificates to protect your credentials.

You receive a message from AAPC: “It’s time to submit your CEUs.” Has it been two years already? Time flies when you’re having fun earning continuing education units (CEU) by attending local chapter meetings, AAPC workshops and conferences, and other educational opportunities. You’re confident, though, that you’ve fulfilled the requirement to maintain your credential(s), and that you saved your original CEU certificates in a safe place. Or did you?

Where’s the Proof?
Using the CEU Tracker on AAPC’s website makes it easy to track and submit your CEUs before your renewal date. There’s a 25 percent chance, however, that AAPC will ask for hard proof of the CEUs you reported. Will you have it?

What do you do with the original certificates after you submit your CEUs? Do you throw them out? Recycle them? Use them for kindling?
AAPC recommends members maintain all of their CEU certificates on file for at least six months beyond their renewal date. Adopting this policy will make your life much easier in case AAPC randomly selects you for CEU submission verification. One member recently found this out the hard way.

Don’t Let This Happen to You
True story: A member needed to verify his CEUs, but his certificates were nowhere to be found. He wisely contacted the education officer at his local chapter, who was very accommodating and helped him retrieve his lost CEU certificates. Although it’s time-consuming, in a rare case such as this, an education officer can usually verify and recreate local chapter meeting CEU certificates. It involves retrieving the original sign-in sheets and confirming attendance at each meeting.

Unfortunately, workshops and seminars cannot be verified. These larger educational venues have separate CEU numbers for each presentation, so there is no way to verify which sessions each member attended.

Have a Backup Plan
You worked hard for your credentials and you continue to work hard to maintain them. Don’t let them slip through your fingers—hang on to your CEU certificates!
Technology Can Help You with Chapter Revenue

There are two ways you can do this:

1. Maintain the original PDFs (or scanned paper certificates) in an electronic filing system.

2. Maintain the original paper certificates in a paper filing system.

If you choose the electronic route, keep in mind that computers are not infallible. Make backup copies of your electronic files and store them on a different computer, a flash drive, or an external hard drive.

You should also consider whether it’s a good idea to store your personal files at work. A work computer, and everything on it, is the property of your employer. If you part ways with your employer, will you be allowed to retrieve your files—not just the electronic ones, but any paper files, too? Chances are, you may be out of luck.

In the end, how you choose to store your certificates is a matter of personal preference. The important part is that you do it.

Although it’s time-consuming, in a rare case such as this, an education officer can usually recreate certificates.

By Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC

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Don’t Stress the First Test

Summit the certification exam using secrets revealed by veteran test-takers.

You have the experience. You have the education. And you have the resolve. You push the button to register for your first credentialing exam—all five hours and 40 minutes of it—and then it hits you:

“What do I do now?”
Prepare Before the Exam

Fortunately, you’re not the first to take an AAPC certification exam, and there’s plenty of great advice you can glean from your local chapter and online. There are also many well-meaning tales that can scare your pants off, so pick the path that works best for you.

AAPC Cutting Edge asked coders for successful exam-taking strategies. Angela Crouch, CPC, said, “Prepare. Prepare. Prepare.” Nearly everyone we talked to agreed that the best way to do that was to study and practice the exam almost daily. Many recommend using AAPC practice exams for each credential. Not only do the practice exams allow you to get a feeling for how the exam is structured, but it helps you develop the pace necessary to complete the exam in time.

There are two schools of thought about how best to work through the questions in the time allotted. Some advocate slogging through the exam from one end to another. While others recommend finishing the exam by not dwelling too long on an extremely difficult question, and going back to the hard questions after the first pass.

AAPC Director of Education Marilyn Holley, RHIT, CPC, CPC-H, CHISP, prefers the latter technique, but she cautions that this can be risky if you don’t keep track of which ones you skipped. To avoid losing track of the questions you still need to answer—and throwing the whole effort out the window—note the skipped questions in the exam booklet. Then, as you return to answer those questions, double check to make sure the exam question number and the number on the answer grid are the same (i.e., question 20 in the exam booklet = question 20 on the answer grid).

James Hargrove, CPC, agrees. “The test is just as much about speed as it is accuracy. Don’t spend more than two minutes on the questions. If you get close to two minutes, skip to the next and go back later,” he advises.

Successful examinees often mention friends or a group who helped them pass. Taryn Linstedt, CPC, advises finding a colleague who can provide support while studying, or getting a study buddy. Many local chapters offer preparation classes, which provide for you an entire room of support.

Prep with Proper Gear

Attempting the exam is like mountain climbing. Mountaineers devote significantly more time to making sure they have proper equipment than they do the actual climb. Not only must the right climbing gear be packed, but additional materials are always added for contingencies.
At least a couple of weeks before, make sure you have the materials necessary for the actual exam:

☐ **Bring the right code books.**
Check www.aapc.com to see what books are permissible and if any additional material is allowed. If you have the wrong books, you won’t be able to sit for the exam.

☐ **Write in your code books.**
This trick helped me most. You can’t bring notebooks or sheets of notes, but you can transfer notes to your books to help you code. Don’t be afraid to write in your CPT®, HCPCS Level II, and ICD-9-CM code books to help you quickly identify which codes can be used in certain situations.

☐ **Highlight the guidelines in your code books.**
Make sure you can easily find the guidelines that matter. Use a highlighter or, if you’re artistic, make meaningful characters or drawings to identify the information.

☐ **Tab your code books.**
Use pre-made or homemade tabs on your books to identify chapters, frequently used codes or sections, guidelines, appendices, and other places so you don’t waste time riffling back and forth looking for something.

☐ **Confirm the date and location.**
Be sure you know the date of the exam and where it will be held. Some members advise practicing the drive to the site to account for bottlenecks, parking, and how long it takes. If you don’t want to do that, get driving directions from maps.google.com or www.mapquest.com, or use a trustworthy GPS.

☐ **Make a reservation.**
Many members suggest that if you’re exam site requires long distance traveling, book a nearby room so you’re well-rested on examination day. No reason to show up with that thousand-mile stare.

☐ **Pick clothes you can layer.**
The room’s temperature will change throughout the exam period, so make yourself comfortable.

☐ **Sweat the small stuff now.**
Make sure you have your photo and member identification cards, plenty of No. 2 pencils, and an eraser. Pack some hard candy to suck on and some ear plugs if you’re easily distracted. Pack up all the items you’ll need at least the night before—not the morning of—the exam.

☐ **Bring food and water.**
There are no intermissions during the exam. Bring a water bottle, but not a noisy one. Stay away from crunchy foods like chips or anything that smells.

Most important, keep practicing, keep studying, and keep a positive attitude. Jenny Oravecz, CPC, told us she studied religiously every day for weeks prior to taking the exam. “I read the chapters over and over and over again, so I could be as familiar as possible with where to quickly locate any code.”
Prepare Mentally

One of the mistakes many examinees make is staying up late the night before the exam, cramming those last few items into their heads. And getting up early to cram is like committing exam suicide. Oravecz also told us, “I would not recommend studying the morning of the exam; use that time to nourish and hydrate yourself, get to your meeting location early and get yourself grounded mentally.”

If you exercise regularly, keep up your routine. Get a good night’s sleep. Have a good breakfast, grab the items you need to take (already organized and packaged for testing), and go early so you can find the perfect chair for the exam.

Sheri Fuchser, CPC, encourages examinees to look at the exam realistically. “As far as physical stress goes, relax! It’s a test, not a sentencing. You’ve studied and you know it. Get a good night’s rest, have a good breakfast, and review for only a little while [don’t cram],” she said. “Then close everything, relax your mind, and go take your test.” Rachael Taylor, CPC, agrees, “Get some rest the night before, and breathe.”

Before they begin their ascension, many climbers take time to center themselves. They breathe deeply and clear their minds to assure they’re in the moment. Though well prepared, every climber knows that it’s each hand and toe hold that makes the climb successful; worrying about making it to the top is fruitless.

Set the Pace and Keep Up Exam Stamina

Well fed and rested, it’s now time to take the exam. Like mountain climbers, you have to take that first step before you can reach the top. Here are some tips to help you take your first steps during the exam and to proceed with a smooth ascension:

- **Have your identification (ID) ready** – You’ll be asked for a photo ID and your membership card.
- **Have your code books ready** – Proctors will review your code books to make sure they are permissible and haven’t been unfairly augmented.
- **Kiss your phone goodbye** – Don’t bring your tablet, computer, or anything else electronic that might distract you and disturb fellow examinees. Some exam sites check phones at the door; if your site doesn’t, turn it off and put it away. You won’t have time to text (“OMG. I’m taking the exam!”) or play Angry Birds.
- **Be a good neighbor** – Remember the worst roommate you’ve ever had? Don’t be like him or her.
- **Listen carefully** – Your proctor will read the instructions and make other announcements. If you don’t understand the instructions given, ask questions before the examination begins.
- **Carefully mark your answer sheet** – Exams are machine graded, so make sure to correctly fill in your selected “bubble” for each question, as shown in the example on your exam grid, to ensure an accurate score.
- **Scan the entire exam when you begin** – Answer the easiest, shortest questions first. This gives you the taste of success.
- **Remember to pace yourself** – You have an average of two minutes and 15 seconds to answer each question. Stay relaxed and do not panic. You’ll be able to finish.
- **Read each question carefully** – Note such words in the question as *not, except, most, least,* and *greatest.* These words are often crucial in determining the correct answer. There are no “trick” questions on the exam, however, so don’t worry about hidden words or meanings.
- **Answer every question** – If you don’t know the right answer, eliminate as many wrong answers as you can, and then select among the remaining possible answers. If you don’t have a clue, guess. A guess is always better than a blank response and guesses often are correct.
- **Use extra time to check your work** – If you finish with some additional time, go back and review any questions you aren’t fully sure you answered correctly. Use your code books again to confirm.

Some members said they actually found the exam fun, a challenge that made them realize how much they knew and how well they code. But remember that not passing the exam on your first attempt is not the end of the world. Refuse to allow a temporary roadblock to shake your confidence or cause you to develop a negative image of yourself and your ability to obtain AAPC certification. Remember: Never a failure, always a lesson. Dust yourself off, check your ropes, and climb back up. Certification is within your reach.

Brad Ericson, MPC, CPC, CPCO, is director of publishing at AAPC.
Intent Matters for Consults

By G.J. Verhovshek, MA, CPC

“Remember the ‘Three Rs’ for Payers Accepting Consults” (June 2013, pages 26-29) generated more than the usual number of reader responses, and a few readers took issue with my insistence that what matters most when coding for consultations are a documented request, reason, and report. Specifically, they suggested what mattered most was intent: That is, did Provider A intend for Provider B to examine the patient and provide advice or opinion, or did Provider A merely refer the patient to Provider B for care?

Great point! I totally agree.

Let’s Revisit Guidance

Several years ago, writing about consultations (“Consult or Not? Here’s How to Know for Sure,” May 2009, pages 20-22), I called provider intent the “crucial fourth factor” (after request, reason, and report) that defines codes 99241-99245 and 99251-99255:

“A consulting physician may perform diagnostic testing or initiate treatment as part of a consultation service … or may even take over the patient’s care at a later date, but the point of a consultation is always the same:

With the consulting physician’s advice as a guide, the attending/requesting physician intends to continue to treat the patient. If the requesting physician intends for the consulting physician to assume immediate care of the patient’s condition, the service is not a consultation, but instead a referral or transfer of care.”

A few months later (“Expel Consultation Code Worries,” August 2009, pages 40-41), I revisited the same theme:

“The first question to consider when deciding if a medically necessary service may be classified as a consultation is, ‘Was the referring physician asking for an opinion or advice so he could continue to treat the patient?’ If not, the service can’t be a consult, regardless of whatever documentation requirements the service might meet.”

Intent really does matter. A lot. As one reader wrote, “I think if everyone focused more on the intent of that visit, rather than having those three Rs dictated into a note, there would be far less coding confusion and misreporting.”

Be Sure Intent Is Explicit

As coders, the only evidence we have of provider intent is in the documentation. We’re not allowed to infer anything (We all know it by heart: Not documented = Not done.). And that’s precisely why the consultation request is so important: It establishes definitively that Provider A is asking Provider B for advice or opinion, and not simply giving a referral. The purpose of the request is to make the intent of the visit explicit.

Consider a hypothetical, but common scenario. Provider A says to a patient, “You should see Provider B about this issue.” The patient calls Provider B’s office and says, “Provider A says I should see you.” Provid-
er B’s office (which will be billing the service) has an immediate responsibility to clarify the intent of the upcoming visit. Is it a consult or a referral? The answer matters not just from a documentation, coding, and billing point of view; it also affects patient care.

A standard consult sheet sent to the “requesting” provider’s office allows for clarity, making the intent of the visit explicit. You might even offer two options, asking Provider A to check one, and to sign, date, and return the form (see example at right).

Likewise, the consulting physician must document the service precisely. If all that sounds like a lot of trouble, well … there’s a reason consultations reimburse at a higher rate than “regular” outpatient or inpatient visits. They’re more work, and ongoing communication between the requesting and consulting providers is part of the deal.

Be Leary of Consult Code Abuse

There’s no doubt consultation codes have been (and continue to be) abused, sometimes out of ignorance of the guidelines, sometimes purposefully. In 2006, the Office of Inspector General (OIG) released a report, “Consultations in Medicare: Coding and Reimbursement,” claiming that as many as 75 percent of services billed as consultations and allowed by Medicare in 2001 did not meet program requirements. The Centers for Medicare & Medicaid Services (CMS) famously stopped recognizing consultation codes 99241-99245 and 99251-99255 on Jan. 1, 2010, largely because the agency felt the codes were so often misapplied.

And over the years, I’ve heard anecdotally from many coders with providers who “seem to want to code a consult for everything.”

The common scenario involves a specialist who bills as a consult every patient sent from a primary care provider. I’ve seen this personally.

I’m an avid bicyclist, but I’ve had my share of accidents. Several years ago, I fell headfirst over the handlebars at 25 mph (An “endo”). A trip to the emergency department (ED) confirmed I hadn’t scrambled my brain (Thank you helmet!), but I did break my nose in several places and earned a few very nasty facial lacerations. The ED physician recommended I see a plastic surgeon to repair the damage, which I did. When I received a bill for the initial visit, I noticed that the plastic surgeon had billed a consult. Of course, the ED physician had no intention to treat me after I left the ED. He referred me to the surgeon for treatment, not for opinion or advice. It was a clear-cut transfer of care, and any auditor reviewing the case would have recognized it as such.

In some cases, a consulting provider may take over the patient’s care subsequent to billing a (legitimate) consultation service. As a rule, however, the requesting provider should be expected to act on the opinion or advice of the consulting provider. It’s inappropriate to bill a consultation simply because the patient arrives at the suggestion of another provider.

Any provider who routinely bills consults should consider very carefully whether the services are really consultations, or are in fact referrals or transfers of care.

- Is there a signed request making the intent of the requesting/referring provider clear?
- Did the consulting provider report back to the requesting provider with advice and opinion?
- Is the documentation clear enough that an objective third party (e.g., an auditor) would agree?

A “no” to any of these questions means you shouldn’t report a consultation.

Provider intent absolutely matters. In my opinion, that’s precisely why it’s so important for the intent to be made explicit in the form of a request, signed and dated by the requesting provider.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.
Understand Documentation from a Risk Perspective

Concise documentation leaves little room for doubt and helps keep you in the clear.

“If everyone would take documentation seriously and just take a bit more time ... as if their life depended on it, there would be VERY FEW issues of litigation.” — Anonymous

Takeaways:
- Quality of documentation helps determine level of risk.
- Make sure documentation is timely, detailed, and complete.
- Take advantage of standardized free text.

If you were asked to summarize a story in which important details were omitted, words were missing, or the language was foreign, do you think you’d get it right? Probably not. Think of medical record documentation as a story and providers as the authors of their patients’ medical history. To set the story straight, documentation must be timely, detailed, and complete. When it is, coders have ample patient-specific, meaningful information on which to base their coding—thereby reducing risk of improper payments and ensuring quality care.

A Thorough Medical Record Is a Multi-purpose Tool

The medical record has evolved from a tool used exclusively by the practitioner into a multi-purpose document. Think of the medical record as:
- a compliance document that shows the chronological accounting of the patient’s health, including adherence or lack of adherence to treatment options;
- a legal document that records the provider’s thoughts and plans; and
- a shared medical document when multiple providers engage in concurrent care.

Make It Timely

Ideally, documentation occurs as soon as possible after an encounter with a patient. Details begin to blur as time lapses between the face-to-face encounter and the actual documentation of the event. Clinical details and other important information may be completely forgotten if not documented in a timely fashion, and this could result in treatment errors.

Sparse or low quality documentation in the medical record also has many repercussions that extend beyond quality of care. For one, it...
makes it difficult to determine if an adverse outcome was due to negligent medical care or factors outside of the physician’s control. If you are asked for a deposition years later, it may be difficult or even impossible to recreate the day or event in question from memory. Documentation may be the only piece of evidence you have in a malpractice case. And without timely, patient-specific details, you don’t even have that.

Don’t Forget the Details

The devil is in the detail. The time to be concerned is when your provider’s documentation does not address these factors:

• Does the note include a rationale for medical decisions?
• Is there documentation for follow up on diagnostic tests?
• What if the patient did not have a test performed after it was scheduled?

Patient “no show” appointments or cancellations could represent a change in the patient’s behavior. A patient may not be taking a medication according to written orders because he misunderstood the directions. Or maybe that patient cannot afford the medication. Without documentation, the story isn’t complete. The note should reflect the attempt(s) to reach a patient with test results or to inquire about a missed appointment. Lack of information could be a jackpot for a plaintiff’s attorney. Remember the old adage, “If it’s not documented, it’s not done.”

Make sure documentation is complete with rich details of the encounter and not full of generic terms such as “normal,” “negative,” “WNL.” Avoid ambiguous terms such as “light work” or “follow up with surgeon.” Instead, paint the picture with qualifying terms, such as “patient may return to work in a limited capacity, which includes no lifting over three pounds,” or “we will call the general surgeon today to get an appointment for his belly pain.”

Use Addenda Correctly

It’s acceptable to add an addendum to a note to clarify information or explain a change. When adding an addendum to the record, make changes in a timely manner so the details are fresh in the provider’s mind, and be sure the date and time is included. A red flag could be raised if months have elapsed before an addendum is added. For example, there would be no explanation for two separate addendums dictated for the same encounter, written months apart from each other, and with conflicting information between them.

Check for Signatures, Legibility

Every (written, verbal, or phone) order or note should have a legible signature and date. All forms, questionnaires, and reports should include an indication of review using initials or a signature and a date. Documentation should be reviewed for accuracy or to fill in the blanks where narratives are incomplete. The same holds true for the authentication on an electronic health record (EHR). Errors or omissions could result in patient harm, and malpractice.

Keep in mind: The provider ultimately is liable for anything entered in the record as if they recorded it, regardless of who entered it. “Dictated or signed, but not read” does not relieve the provider of liability.

Use Standardized Free Text

EHR systems contain shortcuts and drop-down menus that have a tendency to make patient notes look the same, or “cloned.” The ability to “free” text greatly reduces the cloned look of a note; however, avoid using text lingo or nonstandard abbreviations or terms, which can be dangerous if misinterpreted, and potentially life-threatening to a patient.
**Informed Consent**

“Informed consent” means more than simply stating, “informed consent obtained” in the note. The discussion between the patient and provider should be documented, including the purpose, benefits, significant risks, other specific common risks, alternative treatments and risks, and risks from non-treatment that are specific to this patient. Document that the patient’s questions were answered and that the patient understood the procedure prior to giving informed consent for the service—it’s too late after the procedure has taken place.

The Joint Commission developed a “do not use” list of abbreviations for accredited organizations. This list contains dangerous abbreviations, acronyms, symbols, and dose designations. It was created before the advent of EHRs and does not apply to preprogrammed health information technology systems, but may be considered in the future. It’s wise to follow a policy such as this in all settings. The list can be found on the commission’s website (www.jointcommission.org).

**Happy Ending**

The way a story ends is equally as important as the way it begins. The same can be said about documentation. To know the true outcome, the reader needs more than a brief summary. For example, consider an assessment and a plan that simply indicates, “DM, f/u 3 mo,” compared to, “Type 2 Diabetes Mellitus well controlled on insulin [specific name and dosage indicated] and diet. The patient will return in three months and have A1C drawn prior to that visit.” The detail is in the second ending is clearly better, leaving nothing to the imagination.

Clear, detailed, and timely documentation in the medical record leaves little room for doubt about a patient’s care, and could make all of the difference if you’re ever questioned about a patient’s care or the way that care was coded. And that, my friend, is the end of this story.

Brenda Edwards, CPC, CPB, CPMA, CPC-I, CEMC, has been involved in many aspects of coding and billing for over 25 years. At her current position as a coding and compliance specialist at Kansas Medical Mutual Insurance Company, Edwards’ responsibilities include chart auditing, coding and compliance education, and contributing articles to the company’s website and publication. As an AAPC-approved PMCC instructor, workshop presenter, and ICD-10 trainer, Edwards is a frequent speaker for local coding chapters in Kansas and Missouri and has presented at AAPC regional conferences. She is co-founder of the northeast Kansas chapter and 2013-2014 AAPCCA chair.

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**A&P Quiz**

**Think You Know A&P? Let’s See …**

Mindy presented with complaints of ongoing sinus problems. She has tried many medications over the past year. She gets better for short periods, but the condition has been medically treated four times in the past year and she now presents with acute symptoms again. Which condition is Mindy considered to have?  
A. Acute  
B. Chronic  
C. Recurrent acute  
D. Doesn’t matter, I can just assign the unspecified code

Check your answer on page 65.

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**ICD-10-CM Coding Tip**

**Learn Temporal Parameters**

ICD-10-CM offers coding for acute, chronic, and recurrent conditions. To assign the correct ICD-10-CM code, understand the temporal parameters for each clinical condition. This requires research and a higher level of understanding of clinical conditions. For a patient presenting with sinusitis, for example, you must understand whether the condition is considered acute, subacute, chronic, or recurrent.

The parameters for sinusitis are defined by the American Academy of Otolaryngology - Head and Neck Surgery as:

- Acute - less than four weeks
- Subacute - four to 12 weeks
- Chronic - more than 12 weeks, with or without acute exacerbation
- Recurrent acute - four or more acute episodes per year

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC. She is a member of the Oil City, Pa. local chapter.
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Related or Not? Pass the Modifier Paternity Test

When providers are doing the work for unrelated post-op procedures, get paid for it.

I had an opportunity to audit a surgical specialty that wondered if they could (or should) bill inpatient subsequent visits when seeing their patients after surgery. Good question! The answer is, “Maybe.”

If the post-operative (post-op) visits are related to the surgery, the subsequent visits may not be billed separately. Whereas post-op visits unrelated to surgery should be billed with modifier 24 Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period appended to the ancillary service code.

Questions to Consider
For what condition did the patient have surgery? If this is the same condition that is managed after surgery, it does not qualify for modifier 24 because it’s related. If the patient has arrhythmia, and that is the condition for which he had surgery, post-op visits for arrhythmia generally will not qualify for modifier 24. Whereas if the patient is managed for hypertension in the post-op period, but the surgery was for arrhythmia, this post-operative care might qualify.

Were the post-op conditions triggered by the surgery itself? This is a “you break it, you buy it” policy. For example, if the patient develops a post-op urinary tract infection from the Foley catheter placed during surgery, the post-op visits are not typically separately billable with modifier 24.

Were there other specialties also managing the same condition(s)? If the patient has diabetes and is managed by an endocrinologist post-operatively, it’s probably inappropriate for the surgeon to also bill for the management of this condition.

Chart Notes Must Support Services
In reviewing the documentation, I found the history, exam, and medical decision-making (MDM) documented for the normal post-op care and the care for unrelated condition(s) were mixed together, making
it difficult to see which elements were performed for each condition. This, in turn, made it difficult to determine the appropriate level of service. I call this “Frankenstein documentation,” i.e., merging elements of two different services (routine post-op care and unrelated care) to form a giant beast that makes no coding sense.

**Improve Documentation to Improve Coding**

In this case, I knew there were some billable situations, but the documentation was confusing. I recommended the routine care documentation to be separate from the care provided for the unrelated condition. I created a basic template for the providers to use, as shown in Figure A.

Separating the routine care included in the surgical package from the unrelated care allows the coder to easily identify the elements of history, exam, and MDM performed, and to select the appropriate level of service. Without separate documentation for the two types of care provided, the coder may inadvertently attribute an element of one to the other, leading to over-coding or under-coding.

It may take time for providers to get used to this style of documentation, but it should benefit them in the end. Using a template like this clearly shows the work not included in the global payment for the surgery; and it helps to make a stronger case for reporting visits with modifier 24.

The providers are already doing the work. With some documentation improvements, they may also bill for it.

**Figure A: Documentation template**

<table>
<thead>
<tr>
<th>Procedure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>POD #:</td>
</tr>
<tr>
<td>Past 24-hour events:</td>
</tr>
</tbody>
</table>

**Post-op Care**

**Subjective:**
- Exam:
- Chemistries:
- Radiology:
- Assessment/Plan:

**Unrelated Care**

In addition to the normal post-op care provided today, we addressed the following unrelated conditions:

**Subjective:**
- Exam:
- Assessment/Plan:

**Erin Andersen, CPC, CHC,** is a compliance specialist at Oregon Health & Science University and has over 10 years of coding and compliance experience. She is the president of the Rose City Chapter in Portland, Ore., and a 2012-2015 Region 8 representative for the AAPCCA Board of Directors.
Mitigate the Risks for Using Modifier 25

Know the full scope of scrutiny when claiming same-day, separately identifiable E/M services.

“Be Aggressive with Same-day E/M and Office Procedures” (June 2012, pages 14-15) explained that billers and coders should fight back when payers incorrectly deny codes appended with modifier 25 Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. The article provided clear and thorough examples of appropriate use of modifier 25, and reinforced the importance of going after every available dollar that is due to healthcare providers—especially in this time of shrinking reimbursements and increasing expenses.

But there is more to the story. You should be aware of the scrutiny that modifier 25 claims are under. Through data mining analytics and focused reviews, regulators and private payers have found inappropriate payments issued for modifier 25 claims.

Examples include:

• A November 2005 Office of Inspector General (OIG) report claimed that 35 percent of 431 claims reviewed did not meet Medicare program requirements, which resulted in $538 million in improper payments (https://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf).

• An April 2012 report by UnitedHealthcare® indicated that they overpaid between $3.2 million and $7.8 million in claims processed for the New York State Department of Civil Service for misuse of modifier 25.

• In September 2012, the U.S. Attorney’s Office for the Northern District of Georgia issued a report on an oncology practice that paid $4.1 million to settle a False Claims Act investigation that included the misuse of modifier 25.

Claims Must Withstand Heavy Scrutiny

Inappropriately billing an office visit on the same day as a procedure drives up costs to payers and potentially increases patients’ out-of-pocket expenses. For these reasons, this area of coding must be thoroughly understood to prevent accusations of fraud and abuse. There are ways to mitigate the risk associated with appending modifier 25.

Know the Rules

Modifier 25 indicates that on the day a procedure or service was performed, the patient’s condition required a significant, separately identifiable evaluation and management (E/M) service, above and beyond the other service(s) provided, or beyond the usual preoperative and postoperative care associated with the performed procedure(s). CPT® codes assigned with an “XXX” or “10-day” global period (per the Medicare physician fee schedule) include payment for routine pre- and post-work services. Payers will allow for an additional payment, however, when modifier 25 is appended to the E/M service. Identifying a significant E/M service is key.

Review Modifier 25 Claims

Before submitting a claim for a separately identifiable E/M service, ensure you have appended modifier 25 appropriately and that you have sufficient documentation to support its use. For a claim to be able to stand up to an audit, a medical reviewer must be able to see the additional work involved. This may be evident through new or more severe symptoms in the patient’s history, or possibly a change in the patient’s treatment plan.

Takeaways:

• Payers scrutinize claims with modifier 25 appended.
• Be familiar with the rules for modifier 25.
• Review claims and query providers to assure proper payment.
For example, a patient diagnosed with cancer presents for her scheduled round of chemotherapy. The oncologist sees the patient, checks the patient’s port for infection, and inquires about any side effects. This service would be reported with 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular for the chemotherapy infusion, and the corresponding HCPCS Level II code for the chemotherapy agent.

In an alternate scenario, the same patient presents for her scheduled round of chemotherapy and complains of congestion and a productive cough. The oncologist performs an exam and prescribes an antibiotic and documents the service. This documentation is evidence of significant and separately identifiable work performed. An E/M service would be reported with modifier 25 appended, along with 96372 for the chemotherapy infusion and the chemotherapy agent.

Review LCDs and NCDs
Local coverage determinations (LCDs) and national coverage determinations (NCDs) are invaluable resources for guidance on procedural coding and billing. NCDs are made through an evidence-based process overseen by the Centers for Medicare & Medicaid Services (CMS). In the absence of an NCD, Medicare contractors may create an LCD for coverage or non-coverage of an item or service. NCDs and LCDs are updated periodically, so stay on top of these.

Research Physician Professional Organizations
Determine if any physician professional organizations have recently issued opinions for procedures routinely performed by your specialty, along with coding guidance. These organizations are Medicare’s source of information when writing medical review policies and NCDs. Professional organizations also often advocate to regulators for clarification on coding-related matters, so their websites often provide a wealth of information about coding rules.

For example, the American Academy of Family Physicians (AAFP) recommends physicians ask themselves the following questions in determining if modifier 25 should be used (source: www.aafp.org/fpm/2004/1000/p21.html):

- Did you perform and document the key components of a problem-oriented E/M service for the complaint or problem?
- Could the complaint or problem stand alone as a billable service?
- Is there a different diagnosis for this portion of the visit?
- If the diagnosis is the same, did you perform extra physician work that went above and beyond the typical pre- or post-operative work associated with the procedure code?

Collaborate with Your Providers
Coders and billers are not clinical experts. If there is an uncertainty about whether a separate service should be reported, provide the rules and ask for clarification from the provider or his or her peers. Your providers might recognize the need to improve documentation when such issues are brought to their attention. Sometimes, it may be necessary to ask the question, “If your peers were to review your note, would they be able to determine why an E/M service was separately reported with this procedure?” If there is hesitation in the provider’s response, chances are some education might be warranted.

The importance of you understanding the full scope of your responsibilities cannot be understated. Your job is more than assigning codes or releasing claims as they are presented to you. You owe it to your employer and to your profession to use critical thinking skills when coding and billing provided healthcare services. By doing so, you build credibility as professionals—which, in turn, helps all coders and billers become more relevant to employers. You need to look for ways to capture all the revenue that is due, as well as to be aware of what can potentially open your provider and institution up to outside scrutiny.

Tricia Radatz, CPC, is the director for regulatory compliance at The MetroHealth System in Cleveland, Ohio. She has over 20 years experience in revenue cycle management and most recently has transitioned to healthcare compliance. Radatz is a member of the Cleveland Southwest Ohio local chapter.
Simplify coding by knowing what is packaged into obstetrics care.

Coding for obstetric (OB) services can be complicated. When reporting maternity care, you must know what is included in the global OB package. Per CPT® guidelines, the global OB package includes “uncomplicated care” to the patient in the antepartum period, the delivery, and through the postpartum period.

Let’s begin by examining the antepartum period, delivery, and postpartum period separately. Then, we’ll discuss proper coding when the physician provides all three (e.g., global maternity care).

**Antepartum Care**

CPT® defines antepartum care as beginning with conception and running through delivery. The following services are inclusive to antepartum care (and inclusive to the global OB package), and are not separately reportable:

- Obtaining the patient history (including the initial history and any subsequent history)
- The exam
- Obtaining and recording the weight, blood pressures, and any fetal heart tones
- Routine chemical urinalysis
- Monthly visits up to 28 weeks gestation
- Bi-weekly visits up to 36 weeks gestation
- Weekly visits up to delivery

The following services usually occur during antepartum care, but are not inclusive to the global OB package, and may be reported separately:

- Complications of the pregnancy
- Evaluation and management (E/M) services for problems unrelated to the pregnancy
- Lab tests performed outside of routine chemical urinalysis, including venipuncture
- Surgical complications or other problems related to the pregnancy
- Amniocentesis
- Chronic villous sampling

**Takeaways:**

- Because coding for OB services can be complicated, you must know what is included in the global OB package.
- A large number of antepartum services are intrinsic to the period before labor.
- Append modifier 24 to all E/M services that address pregnancy complications.
If circumstances warrant reporting antepartum services only, code selection is based on the total number of provided antepartum visits.

Antepartum Care-only Reporting
Antepartum care only does not include delivery or postpartum care. When reporting this service, you do **not** report the global maternity package. These circumstances occur commonly in the OB world. Examples are if the patient changes insurance payers during the maternity care, if the patient transfers care to another provider, or if the patient miscarries or aborts the fetus.

In most circumstances, the average number of antepartum visits for uncomplicated care is 13. Antepartum visits totaling fewer than 13 should be reported separately from the OB package using codes for antepartum care only. If circumstances warrant reporting antepartum services only, code selection is based on the total number of provided antepartum visits.

- If four to six visits are provided, report 59425 *Antepartum care only; 4-6 visits*.
- If seven or more visits are provided, report 59426 *Antepartum care only; 7 or more visits*.

When reporting antepartum care, claim the correct code only once. For example, a physician provides eight antepartum visits to a patient. After the eighth visit, the patient changes insurance carriers. The eight visits prior to the insurance change are separately reportable to the initial payer. To code this scenario correctly, the physician reports 59426 (one unit).

If only one to three antepartum visits were provided, report the appropriate E/M codes, according to CPT® guidelines. For example, a provider performs one antepartum visit to an established patient. The visit includes an expanded, problem-focused history and exam, with medical decision-making (MDM) of low complexity. Prior to a second visit, the patient suffers a spontaneous abortion. To code this scenario correctly, based on the key components and the patient’s status, the provider reports E/M code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; Medical decision making of low complexity*.

**Delivery-only Services**
Delivery codes include admission to the hospital, the hospital history and physical, the exam, and management of uncomplicated labor. Any E/M services provided within 24 hours of delivery are also included (E/M services that occur more than 24 hours of the delivery may be separately reported). All inpatient E/M services and postpartum services are also included in the delivery codes.

The delivery codes also include:
- Inducing labor using pitocin or oxytocin
- Injecting anesthesia
- Artificial rupturing of membranes that occur prior to delivery
- Inserting a cervical dilator for vaginal deliveries, if the insertion occurs on the same date as the delivery. If the insertion occurs on a separate date from the delivery, the insertion is separately reportable.
If a provider performs the delivery only, and provides no antepartum or postpartum care, code selection depends on the type of delivery ...

- Delivery of the placenta is also included unless it occurs at a separate encounter from the delivery of the baby. An example of this would be when a patient delivers her baby enroute to the hospital and, following admission, the provider delivers the placenta. In this case, the delivery of the placenta may be separately reported.
- Repair of any minor lacerations (i.e., first or second degree). If extensive lacerations (i.e., third or fourth degree) must be repaired, modifier 22 Increased procedural services may be appended to the delivery code. If lacerations are repaired by a provider who is not the attending, CPT® guidelines direct that code 59300 Episiotomy or vaginal repair, by other than attending physician may be reported by the provider repairing the lacerations.

Services that are excluded (or not inclusive) of the delivery code, and may be reported separately, include:
- Scalp blood sampling on the newborn
- External cephalic version
- Administration of anesthesia such as an epidural

**Delivery or Delivery with Postpartum Care-only Coding**
If a provider performs the delivery only, and provides no antepartum or postpartum care, code selection depends on the type of delivery:

- 59409 Vaginal delivery only (with or without episiotomy and/or forceps)
- 59514 Cesarean delivery only
- 59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
- 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Because delivery only is performed, and the provider is not performing the entire global maternity package, any inpatient E/M visits related to the delivery are separately reported.

**Example:** A patient presents to the hospital at 39 weeks gestation in the early onset of labor. The patient delivers a female infant vaginally with the help of her primary obstetrician/gynecologist (OB/GYN). The patient develops a third-degree vaginal laceration during the delivery that is repaired by the OB/GYN. In total, the patient’s OB/GYN performs 14 antepartum visits, the delivery, and all postpartum care. To correctly report this scenario, the physician will report 59400-22 for the global maternity care. Repair of minor vaginal lacerations are included in the delivery, but extensive lacerations may be reported by appending modifier 22 to the global code. In this case, the patient developed a third-degree laceration, which is considered major. If a provider assists the patient’s primary OB/GYN with the delivery, and is claiming no antepartum or postpartum care, report the appropriate delivery-only CPT® code and append modifier 80 Assistant surgeon.

**Example:** Dr. A is the patient’s primary OB/GYN. The patient presents to the hospital in labor. The delivery appears to be complicated. Dr. B, who is on call with the hospital, is called in to assist Dr. A. The patient delivers a healthy baby girl via VBAC. Because Dr. B only assisted with the delivery (she provided no antepartum care and Dr. A is providing all postpartum care), her services are reported with 59612-80.

If the provider performs the delivery and also plans to provide postpartum care (but he or she did not provide any antepartum care), CPT® specifies the following codes, based on the type of delivery:

- 59410 Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care
- 59515 Cesarean delivery only; including postpartum care
- 59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
- 59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care

**Example:** A patient delivers a male infant via cesarean. The patient does not have a primary OB/GYN and has had no antepartum care. The physician performs the cesarean and orders the patient to follow up in his office for postpartum care in two weeks, which the patient does. To correctly code this encounter, the physician reports 59515.

**Postpartum Care**
Per ICD-9-CM guidelines, postpartum care starts immediately after delivery and runs for six weeks. Check with the payer for its specific policies on postpartum care, as policies may vary. For example, CIGNA® allows six weeks postpartum care for vaginal deliveries, but extends the period to eight weeks for cesarean deliveries.

If the provider is reporting the global maternity package, all postpartum visits are included in the global code. If the provider is not claiming the global maternity package, and is providing postpartum care only, report 59430 Postpartum care only (separate procedure). This code includes all after-delivery E/M visits related to the pregnancy.
Example: A patient vaginally delivers a healthy infant. The patient moves to another town immediately following her delivery, and presents to a new OB/GYN provider for postpartum care. Because the new OB/GYN is providing only postpartum care, proper coding is 59430.

Coding Global Maternity Care

If the provider may report routine global maternity care (which includes antepartum care, delivery, and postpartum care), do not report three separate codes. Instead, report a single code, based on the type of delivery:

- **59400** Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
- **59510** Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
- **59610** Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery
- **59618** Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery

Check with your specific third-party payers before reporting the global OB package, as payer policies on what is included in the global package may differ.

Complications of Pregnancy, Unrelated Issues

If a patient develops complications of pregnancy or the provider treats the patient for an unrelated problem, these visits are excluded from the maternity global package and can be reported separately. Append modifier 24 *Unrelated evaluation and management service by the same physician during the global period* to all E/M services that address the pregnancy complications or unrelated issues. Modifier 24 is needed to alert the carrier that the E/M service(s) is unrelated to the global OB package (for a detailed explanation, see “Related or Not? Pass the Modifier 24 Paternity Test” on page 24).

Example: An established patient at 22-weeks gestation is admitted to hospital observation with pre-term labor. The patient’s OB/GYN visits the patient in observation and performs a comprehensive history, exam, and MDM of moderate complexity. The next day, the OB/GYN returns and determines the patient has improved. The patient is discharged from observation care with orders to follow up in the OB/GYN’s office in one week. Correct coding for these encounters:

**Day 1**

- **99219-24** Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.

**Day 2**

- **99217-24** Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from “observation status” if the discharge is on other than the initial date of “observation status.”)

Remember: The global maternity package includes uncomplicated care. Because this patient was diagnosed with pre-term labor and admitted to observation, this is not uncomplicated care and, thus, it is separately reportable with the observation E/M codes. Modifier 24 is needed to indicate these encounters are unrelated to the global maternity package.

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Why Are You a Coder?

AAPC Cutting Edge wants to know why you chose coding as a profession. Tell us why you’re a coder, how you got to where you are, and your future coding goals. Send your inspirational coding success stories to AAPC Executive Editor Michelle Dick (michelle.dick@aapc.com).

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Successfully Capture HPI Elements in Psychiatry E/M Notes

Major revisions in CPT’s® Psychiatric section brings changes to reporting mental health services.

Prior to 2013, psychotherapy code sets contained options for reporting services with or without evaluation and management (E/M) components. As of Jan. 1, 2013, any E/M service a psychiatrist performs must be reported using the same E/M code set (99201-99215) that other specialists have been using for years. This is new territory to many psychiatric providers, and raises an important question: What do you do when the chief complaint involves mental health?

Define Mental Health HPI
The history of present illness (HPI) component of an E/M service is comprised of eight elements: location; quality; severity; timing; duration; context; modifying factors; and associated signs and symptoms. These elements can most easily be applied to physical (as opposed to emotional/mental health) complaints, which creates a challenge for the psychiatry provider documenting the service, the coder choosing the correct E/M code for billing purposes, and the compliance professional reviewing the claim to substantiate the charges billed.

Finding mental health HPI elements may be easier if you can think outside of the box. When looking at each HPI element, here are some clues as to the language a coder or compliance reviewer might expect to see in a psychiatric E/M HPI:

• **Location:** Regarding mental status, location could correspond to domain (e.g., mood, thought process, perception, etc.)
• **Quality:** Descriptive language (e.g., forgetful, depressed, disorganized, hallucinating)
• **Severity:** Language that relates to how bad the problem is (e.g., “8 out of 10,” controlled, uncontrolled)
• **Timing:** Language that relates to when symptoms are experienced, such as in certain situations or time of day
• **Duration:** Onset of symptoms and how long symptoms last
• **Context:** Psychosocial factors related to the problem
• **Modifying factors:** What brings on or relieves the problem?
• **Associated signs and symptoms:** What else is happening? (e.g., loss of functions/drives, such as appetite, weight, libido, etc.)

**Takeaways:**
- Changes to psychiatric codes in CPT® 2013 require familiarity with HPI.
- Think outside of the box to better discern HPI elements in the E/M code.
- Psychiatric organizations provide excellent examples for documentation.
Findining mental health HPI elements may be easier if you can think outside of the box.

Learn by Example
The American Psychiatric Association and the American Academy of Child & Adolescent Psychiatry have published vignettes of established patient visits (99213-99215) for behavioral health diagnoses. The following is the HPI from one of their sample clinic notes:

CC: 70-year-old male seen for follow-up visit for depression. Visit attended by patient and daughter; history obtained from both.

HPI: Patient and daughter report increasing distress related to finding that he has repeatedly lost small objects (e.g., keys, bills, items of clothing) over the past 2-3 months [duration]. Patient notices intermittent [timing], mild [severity], forgetfulness [quality] of people’s names and what he is about to say in a conversation. There are no particular stressors [modifying factors] and little sadness [associated signs and symptoms].

(Source: www.aacap.org/galleries/default-file/EM_Patient_Examples.pdf)

Remember also that patients don’t always end up at a psychiatrist’s office for mental health issues. For instance, primary care providers, such as a family doctor or internist, may treat patients with mild depression or anxiety. This means coders and compliance reviewers may encounter clinic notes with behavioral health undertones documented by any number of specialists.

Joyce Will, RHIT, CPC, has more than 25 years of experience in ICD-9-CM, CPT®, E/M coding, and professional services compliance reviews. Will is a physician services consultant with Health Information Associates, a healthcare consulting firm specializing in coding compliance review, education, and contract coding services. She is secretary/treasurer of the AAPC Mount Juliet, Tenn., local chapter.

For more about the change to psychiatric codes in the 2013 CPT®, check out “Renew Your Understanding of Psychiatric Services,” June 2013, p. 32.
Skin Neoplasms: Uncover the Facts for More Precise Diagnosis Coding

Stellar skin cancer coding requires more than just an understanding of ICD-9-CM principles for neoplasms.

The more you know about skin cancer and anatomy, the easier it will be to code for benign and malignant neoplasms diagnoses using ICD-9-CM guidelines and proper sequencing. Let’s start with the basics.

Differentiate Skin Cancers

According to the Centers for Disease Control and Prevention (CDC), skin cancer is the most common form of cancer in the United States. The primary cause is ultraviolet radiation, most often from the sun. Skin cancers are named for the type of cells affected. The three principal types are basal cell carcinoma, squamous cell carcinoma, and melanoma.

Basal Cell Carcinoma (BCC)

Basal cell carcinoma is the most common form of skin cancer, and the most common of all cancers. More than one in three cancers is a skin cancer, and most of these (more than two million per year in the United States) are BCC, according to the American Academy of Dermatology (AAD).

Basal cell carcinoma starts in the epidermis and usually develops on the sun-exposed areas of the body, such as the scalp, face, and (especially) the nose. BCC almost never spreads to other parts of the body.

Squamous Cell Carcinoma (SCC)

Squamous cell carcinoma is the second most common skin cancer. The AAD reports about 700,000 new cases of SCC each year. This form of skin cancer usually remains confined to the epidermis for some time, but eventually will penetrate to the underlying tissues if not treated. As with basal cell carcinoma, SCC most often occurs on sun-exposed areas of the body, including the face, neck, bald scalps, hands, arms, and back.

Melanoma

Melanoma is the most serious type of skin cancer. In 2009, the CDC indicated over 61,000 newly diagnosed cases of melanoma and over 9,000 melanoma-related deaths. If diagnosed and treated early, however, melanoma is almost 100 percent curable.

There are four types of melanoma: superficial spreading melanoma (most common), lentigo maligna (melanoma in situ), acral lentiginous melanoma, and nodular melanoma.
If a histologic term (adenoma, melanoma, etc.) is documented, you should first reference that term, rather than going to the Neoplasm Table.

Ready to Code? Refer to ICD-9-CM Guidelines
Guidelines for neoplasms may be found in section I.C.2 of the ICD-9-CM manual. Chapter 2 of ICD-9-CM contains the codes for most benign and all malignant neoplasms (the relevant codes are in the range 140-239). To assist in code selection, the ICD-9-CM Index contains a Neoplasm Table located under the primary heading “Neoplasm.” To confirm neoplasm location and behavior (primary, secondary, in situ, etc.), you ideally should have a pathology report available. It’s important to have a confirmed diagnosis because to label a patient with an unconfirmed diagnosis (especially a diagnosis of cancer) may lead to serious negative consequences.

If a histologic term (adenoma, melanoma, etc.) is documented, you should first reference that term, rather than going to the Neoplasm Table. Sometimes the referenced term will instruct you to go to the Neoplasm Table; sometimes it will give you code choices to reference in the Tabular List.

Melanoma is a good example of when you should use the alphabetical Index to locate a code in the Tabular List.

Case In Point
A patient has a melanoma on the skin of the nose. If you use the Neoplasm Table, you would look up “skin,” with the subterm “nose,” which would send you to “Neoplasm, skin, face.” Under “face,” there are choices of “basal cell,” “specified type,” and “squamous cell.” You might consider the “specified type” as the correct choice because melanoma is specified, which would lead you to 173.39 Other specified malignant neoplasm of skin of other and unspecified parts of face. But if you first reference the alphabetical Index for the term “melanoma,” with the subterm “nose,” you would instead be sent to 172.3 Malignant melanoma of other and unspecified parts of face, which is the more precise and correct code.

Always look first under any documented terms provided before accessing the Neoplasm Table to ensure the most appropriate code selection.

Sequencing Is Important
Sequencing of codes may be a factor when reporting neoplasms. Instructions may be found in the ICD-9-CM Official Guidelines for Coding and Reporting (I.C.2.a – I.C.2.c).

If treatment is directed at the malignancy, the malignancy should be the first-listed code. The exception to this rule is when a patient presents solely for administration of chemotherapy/immunotherapy/radiation therapy. At that point, an appropriate code from category V58 Encounter for other and unspecified procedures and aftercare would be the first-listed code because that is the main reason the patient is presenting, followed by the neoplasm code.

The V58 category code choices are:

V58.0 Encounter for radiotherapy
V58.11 Encounter for antineoplastic chemotherapy
V58.12 Encounter for antineoplastic immunotherapy

If the patient has a metastatic malignancy, the order of the codes is driven by the reason for the encounter. If it’s for the primary site, that is the first-listed code. If it’s for the secondary site, it will be the first-listed code. Documentation must be clear to ensure codes are properly reported in the correct order.

Case In Point
A patient with melanoma of the thigh that has spread to the inguinal lymph nodes presents for interferon alpha 2-b immunotherapy treatment for the metastatic site of the lymph nodes.

Proper coding and sequencing is:
V58.12
196.5 Secondary malignant neoplasm of the lymph nodes of inguinal region and lower limb
172.7 Malignant melanoma of skin of lower limb, including hip
The skin is the largest organ system of the body. It’s made up of two layers: the epidermis and the dermis. The epidermis has four to five layers, called stratum, which include the stratum corneum, stratum lucidum, stratum granulosum, stratum spinosum, and stratum basale. The stratum basale is the layer of reproducing cells that lies at the base of the epidermis and receives its nourishment from dermal blood vessels.

The epidermis contains mostly dead cells and has no blood vessels. The epidermis contains melanocytes, which are cells that produce melanin, a dark brown pigment. The difference in people’s skin color comes from the amount of melanin melanocytes produce and distribute.

The epidermis is important
because it protects against water loss, mechanical injury, chemicals, and microorganisms.

The dermis has two layers (papillary dermis and reticular dermis) and lies under the epidermis. The dermis contains structures that nourish and innervate the skin. They are nerves/nerve endings, cutaneous blood vessels, hair, nails, and glands. The dermis binds the epidermis to underlying tissues and consists of connective tissue with collagen and elastic fibers within a gel-like ground substance.

Below the dermis lies the subcutaneous tissue. The subcutaneous tissue is made up of loose connective tissue and adipose tissue, which provides insulation and protection for deeper structures. It binds the skin to underlying organs and contains the blood vessels that supply the skin with blood.

In a second example, a patient presents to have a basal cell carcinoma excised from his nose and a basal cell carcinoma excised from his back.

Proper coding is:

173.31 Basal cell carcinoma of other and unspecified parts of the face
173.51 Basal cell carcinoma of skin of trunk, except scrotum

There is no sequencing rule when a patient has two primary carcinomas and presents for treatment for both. 173.31 and 173.51 are the proper codes, but the codes do not have to be in this order.

The ICD-9-CM Official Guidelines for Coding and Reporting also gives instruction on many other issues pertaining to skin cancer, including coding for complications, encounters for surgical removal, and encounters for pain control/pain management. Be sure to look to these guidelines if you need clarification on a diagnosis coding issue.
Save Money: Claims Follow Up 101
Nine basic tips will help you recoup money for unpaid claims.

The No. 1 way to improve your practice’s bottom line is to resolve outstanding claims efficiently and effectively. Keep these tips in mind to take the pain out of claims follow up.

1. Save time by using payer websites as much as possible to check claim status and eligibility, to search for payment policies and coverage criteria, and to submit claim corrections and appeals.

2. Determine whether a claim is outstanding. If it has been processed, was it denied? Is payment the patient’s responsibility?

3. For an outstanding claim, verify whether it has been received. This is a good time to confirm whether the patient’s coverage is still active because some plans can retroactively terminate.

4. For a claim that has been received, make sure it’s being processed. Get an estimate of when it should be processed, and make sure no additional information (e.g., medical records, info from the patient, an explanation of benefits, etc.) is needed to complete processing.

5. If the claim was not received, verify the billing address, and then see if the claim can be resubmitted electronically or by fax. When resubmitting to the same address, send the claim by certified mail to ensure you have proof of timely filing—in case it gets “lost” again.

Know your state’s prompt pay laws. Many states, such as Texas, Oklahoma, New York, Ohio, etc., require insurers to either pay or deny claims within 45 days of receiving a “clean claim” (a claim that includes all of the basic information necessary to adjudicate it).

States may also specify time lines in which insurers are legally obligated to provide requested information in writing, such as detailed rationale supporting a denial. For example, in Texas the deadline is 30 days.

Become familiar with the concept of the “mailbox” or “postal” rule, and find out if it’s applicable in your state. This rule presumes that if a claim is mailed to the proper address, it has been received after a specified amount of time (five days, per Texas law).
Establish a process for contacting patients to request information (coordination of benefit updates, for example) on behalf of their insurer. It may help to create a template letter for commonly requested items, which then can be drafted quickly, as necessary. Call the patient to inform him or her that you will be mailing a letter as a reminder. Establish a time limit for patients to respond to your request (e.g., 10 days) and notify them that they will be billed for the full amount of their charges if they fail to follow through. Often, seeing the bill is incentive enough to encourage patients to do their part.

For denied claims, gather as much information about the denial as possible. You need to understand exactly why the charge was denied to find a resolution.

For example, if the denial states “non-covered service,” you should know why it isn’t covered. Is the service always excluded from coverage, or is there something about the way it was billed (e.g., the diagnosis, the patient’s age, etc.) that caused the denial? Is the denial limited to the patient’s group/plan or is it a company-wide coverage policy? If possible, try to locate relevant coverage information in writing to guide you.

Submit corrected claims and appeals within the appeal deadline for each payer. Clearly mark corrected claims and appeals so they are distinguishable from new claim submissions; otherwise, you’ll receive a “duplicate claim” denial.

Keep detailed records of your efforts to follow up on claims, including the names of people you speak with (as well as the contact date and time). Note specific information they relay to you and any actions you take (such as re-filing the claim or verifying eligibility). This will help you to recall information if you need to address the claim again in the future, and it will prevent you from doing the same work twice.

When resubmitting to the same address, send the claim by certified mail to ensure you have proof of timely filing—in case it gets “lost” again.

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References:
- www.insurance.ohio.gov/Consumer/Pages/InsPrmpt2.aspx
- www.ok.gov/oid/Consumers/Consumer_Assistance/Claims_Process.html
- www.oasas.ny.gov/admin/hcc/mancare/documents/KnowYourRights.pdf
- www.statutes.legis.state.tx.us/Docs/IN/htm/IN.542.htm
- Sec. 542.055. Receipt of Notice of Claim
- Sec. 542.056. Notice of Acceptance or Rejection of Claim
- Sec. 542.103. Deadline for Providing Requested Information
- www.tdi.texas.gov/hprovider/ppsb418faq.html#toc2
- SB 418 Prompt Pay legislation states that “if a claim ... is mailed, the claim is presumed to have been received by the carrier on the fifth day after the claim is mailed.”
Practice Management

By Virginia Outlaw, CPC

Tips for New Business Manager Success

It isn’t easy being the new kid on the block, so start with your best foot forward.

Congratulations! You just landed the business manager position at a physician office. As the “new kid on the block,” you must not only gain control of accounts receivable (A/R) and charge input, but also establish a bond with the business office staff you’re managing. Without their cooperation, dedication, and strong desire to excel, you’ll have difficulty achieving financial success.

Get Started on the Right Foot

The first step is to meet with the staff as a team and note the body language during the meeting. Disinterested and unengaged employees will be the first to show their true colors by gazing into the distance, crossing their arms, or drawing on paper. These will be the hardest employees to win over.

Pass out a questionnaire to the staff, and announce your plan to meet with each staff member individually to discuss his or her answers. Suggested questions might be:

• Are you satisfied with your current job duties?
• Is there another position you would like training on?
• Do you have everything you need to perform your job properly?
• Do you receive continuing education for your job?
• When performing your job duties, what are your strongest and weakest points?
• Do you feel upper management listens to your concerns?
• Is communication a problem in the workplace?
• What are your goals for the coming year?

Set a time on each employee’s calendar and be prepared to listen. Some employees will come with two or three detailed pages of their thoughts, suggestions, and questions. After all, employees see this as private time to find out what may happen in the office. A few employees may use this time as an attempt to discuss other staff members. It’s best to direct these individuals back to the conversation at hand.

Work with Different Personality Types

As you meet with employees, try to get a feel as to what their attitudes and habits may be. There are four common personality types, based on the HRDQ® Personality Style Model:

<table>
<thead>
<tr>
<th>Takeaways:</th>
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<tbody>
<tr>
<td>• If you’re a new practice manager, first meet with your staff.</td>
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<tr>
<td>• Learn to work with different personalities.</td>
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<tr>
<td>• Make a plan to build your team.</td>
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Group No. 1 – Direct
These employees are strong, reliable, hardworking, independent, and require little or no supervision to perform their job function. Their weaknesses are harshness and “speaking their mind” without any thought as to how their words may be perceived by others. They also tend to hold a grudge when they feel co-workers are not working up to par.
This will be the first group to work with, as these employees will help to lead the other staff members in the direction of improvement. Your goal is to help them define necessary office changes and encourage the staff to draft a policy for needed improvement.

Group No. 2 – Spirited
These employees are compassionate, friendly, generous, talkative, extremely outgoing, and like to be the center of attention. They may also be unstable, nonproductive, unable to follow through on work assignments, and require constant monitoring.
An employee of this nature may require a managerial decision. Can you turn the employee around to become productive within the practice, or will you need to provide documentation to the medical practice indicating the employee should be terminated? An attempt should always be made to save an employee.

Group No. 3 – Considerate
These are your easygoing employees: Calm, but at times quite humorous. They are extremely dependable and rarely miss work. They try to see both sides of a story when making a decision.
Group 3 personalities make good employees, but require just a little extra praise and acknowledgement. They may need additional training in their job functions and a full understanding of what the complete A/R cycle represents to provide them with more security. Their lack of knowledge contributes to worry and indecisiveness, which makes them insecure.

Group No. 4 – Systematic
These are self-disciplined employees who, in an interview, appear to be the best you can hire. They are organized and able to think through a process from start to finish, and require little or no supervision to perform their job function.
Their weakness is the inability to relate to co-workers or management. They may have an extremely negative attitude and, when frustrated, take it out on co-workers. Other staff may ostracize these employees, which may result in an employee’s retaliation against an individual or a whole team. They tend to be non-professional in interactions with management.
Once again, the manager is placed in the position of determining if the employee should be kept. His or her work is good; however, the personality traits are almost like a poison spreading through the group. An attempt should always be made to save the employee before punitive action, such as dismissal, is taken.

Make a Plan to Build a Team
The first year may be rocky as you realize the staff is not trained sufficiently or does not work as a team. Positive change will not happen overnight (or even within six months).
Make a schedule for necessary changes and to plan a time frame for each improvement.

Monitor your progress, and ask yourself:
• Is the office moving forward or staying stagnant?
• Are changes occurring too quickly for everyone to keep up?
• Should I revise the plan?
If the office is ahead of schedule, recognize the employees who helped achieve this. After all, it took all of them to boost the business office ahead of schedule under new leadership.

Remember: You Are Being Judged, Too
Know that just as you are sizing up your staff, they are doing the same to you. Many managers are Group No. 1 people, such as myself. Whatever your personality type, “own up” to your weaknesses and seek positive change within yourself. For example, with the help of a professional job coach, I came to understand the various styles of management, learned to identify undesirable personality traits, and now recognize the value of teamwork. This training alone has made a phenomenal change in my management style, allowing positive interaction with staff, especially when recognizing their hard efforts.
Lastly, if you’re a new kid on the block: Best of luck in your endeavors!

Virginia “Jennie” Outlaw, CPC, has worked as a business manager for First Coast Cardiovascular Institute since January 2013. She worked in the finance industry for 20 years before entering the medical industry. Outlaw was a compliance officer for 10 years, including time working as a business manager at the University of Alabama. As a business manager at the University of Florida, she focused on employee education. She works with the Education First (EF) Foundation for Foreign Study and hosts exchanges students. Outlaw is a member of AAPC’s National Advisory Board and is local chapter president of the AAPC St. Augustine local chapter. She has chaired the educational seminars held by the St. Augustine chapter for the last four years.
Organize Your Workspace for Maximum Efficiency

“A place for everything and everything in its place,” I always say. Organized workspaces allow for efficient workflows, which in turn can lower employee stress levels and increase productivity. Here are some tips to get you to that happy place.

Start by completely clearing out your workspace.

Use a large box to temporarily hold all of the items from your desktop and drawers. Now, sit at your empty desk and visualize how you would like it to function. The things you need most often should be the easiest to access and to put away.

When you have a clear vision of your new and improved workspace, replace each item one at a time, starting with the largest piece of equipment—for most of us that would be a computer monitor. If you have a small workstation, consider getting a desktop stand for your monitor so the space underneath is still usable. A stand also serves to raise your monitor up to eye level, which is more ergonomic—less neck pain and eye strain equals less physical stress.

To ensure Health Insurance Portability and Accountability Act (HIPAA) compliancy, make sure to angle your monitor so no one else can see what is on your screen.

The next piece of equipment to put back is the telephone. When choosing a location, consider whether you are right- or left-handed. Position the phone so it is easily accessible to your dominant hand.

Arrange the contents of your desk drawers according to importance.

Keep items that you use every day in the upper drawers so they are quickly accessible. If you have a drawer for pens and pencils, separate them so when you reach for a pen you don’t pull out a pencil. The next drawer might be for stationery and envelopes. Keep only items that pertain to correspondence in this drawer.

As you arrange your work area, be sure to leave space to add new items without disrupting the scheme. You shouldn’t have to change everything to accommodate each new thing. Designate a specific area for items that need to be put away, so they aren’t misplaced.

Think accessibility, and relax.
To discuss this article or topic, go to www.aapc.com

Avoid the trap of thinking “neatness = organized.”

A better way to think of it is “functional and efficient = organized.” For example, you could argue that the “neatest” way to organize books on a shelf might be to line them up by size or color. But if you’re looking to find a book quickly, it’s better to categorize them by subject or alphabetically by title, etc. Neatness counts, but organization is more important.

Continue to empty your box in order of importance and usage frequency until you’ve removed all of the items. If there are things in the box that you don’t use very often (or at all), consider storing them somewhere other than at your desk, such as in a filing cabinet. Throw out what you no longer need.

Now, step back and admire what you have accomplished. It’s a good feeling when you can look at your workstation and know where everything is.

Stay organized.

The organization you just accomplished will only work if you put things back where they belong when you finish using them. This shouldn’t be a problem for you, however, now that there’s a place for everything, and everything is in its place.

Sylvia Partridge, CPC, CGSC, has over 42 years of experience in the medical field. She has been a general surgery coder since 1992 and works for Athens Regional Specialty Services, a hospital owned physicians group. She earned her CPC® in 2001 and spent a year teaching coding at a local vocational school. Partridge is a three-time past-president of the Athens, Ga. local chapter, and a member of the AAPC National Advisory Board.

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Redefined Business Associate Agreements Create Concern

Guard against liability when someone else mishandles your practice’s patient records.

True story: A journalist reported finding patient medical records at a trash transfer station. An investigation revealed that a Massachusetts physician group’s billing company improperly disposed of the private health information (PHI). Although there was no direct evidence of patient harm, a court ruled this event a security breach under the new Health Insurance Portability Accountability Act (HIPAA) Omnibus Rule. The physician group was fined $140,000.

Rule Changes Require Quick Action

According to John Brewer, president of Med Tech USA, LLC, a firm that provides HIPAA compliance consulting and solutions, “The HIPAA Omnibus Rule has altered business associate agreement (BAA) requirements pretty drastically. Before, having a BAA basically allowed you to wash your hands of liability if the business associate had a breach of your data. Now, a practice has to put any business associate under more scrutiny.”

The rule was enacted in January. Practices have until Sept. 1 or Sept. 23 to comply, depending on whether the BAA is with a new associate, or an updated version of a BAA is in place with a current associate, respectively.

“One example is that a billing service—no matter how big or small—must have privacy and security policies, just like a practice does,” he said.

Yet, many billing services, as well as other vendors, don’t have such policies. Government studies show that almost half of all breaches come from business associates. With fines now being calculated per incident (i.e., per patient’s data breach), you can’t afford not to scrutinize every associate’s privacy and security procedures.

The Massachusetts physician group dropped the ball. “There was no BAA in place when they shared PHI with the billing service, and the billing service had failed to train its workforce about HIPAA guidelines,” Sacopulos said. His message to practices: Be prepared and pay attention. “If the practice had policies and procedures in place, the breach may still have occurred, but the fine would likely have been a fraction of the $140,000,” he said.
All home-based workers must understand security and privacy requirements ... our client offices often access PHI from the same home computers they allow their kids to play games on.

Buyer Beware
Karen Zupko, president of KarenZupko & Associates, Inc., a practice management consulting and training firm based in Chicago, said she encounters this sort of negligence all the time. “We commonly see clients hire small billing companies that can get a claim out the door, but that are unaware of the extraordinary regulatory environment in which we all live,” she said. “Practices that engage in these relationships carelessly put their business at great risk.”

For example, Zupko asked a recent client to provide a copy of his billing company’s service contract. “The only person who had signed it was the doctor,” she said. “The vendor never co-signed and executed the agreement.”

Three other clients Zupko recently visited used billing companies that could produce neither a service contract nor a BAA. Digging deeper, she discovered some of the same concerns Sacopulos has for his physician clients. “These companies had no policies about what to do during a breach, no internal security audit procedures, and no HIPAA training for employees,” Zupko said. “I was very distraught to find casual email communication between the practice and the billing service.”

“You’re now on the hook for everyone you’re doing business with: every vendor, every business partner, anyone who has access to patient data,” said Sacopulos. “Each BAA must have a security policy, a privacy policy, and a breach notification procedure in place and ready to be used in case a breach occurs.”

What’s more, Zupko added, “Practices must insist on vendor accountability and responsibility.”

Initiate a Frank Discussion
“I tell doctors and practice managers that if the billing company can’t answer a few basic questions, they probably don’t understand HIPAA,” said Brewer. He recommends asking the basics, such as:

- What is your computer password policy?
- How often is electronic data backed up?
- Is this data ever taken off site and if so, is it encrypted when this occurs?
- How often does HIPAA training occur?

This line of questioning engages a frank discussion that practices must have with billing companies, as well as any other business associates with whom they share PHI.

“You entrust a billing company with your patient records and financial data, do you really want to do business with a company that carries no liability insurance? Do you want to give access to a company that hires without conducting background checks and doesn’t require HIPAA training for employees?” Zupko asked. “A proper BAA ensures these requirements are met.”

Most of the time, the right business infrastructure in small billing companies does not exist, experts say. And there may not be good accountability systems in place as a result. That doesn’t mean you shouldn’t work with them. But it does mean your practice must take the lead when it comes to the privacy and security of your patients’ PHI.

Who Has Access to Your Accounts?
As part of your assessment of a billing company, verify that they perform background checks on all their employees.

“I’ve got five cases where people have embezzled money from the billing company or the practice,” Sacopulos said. “You are turning over your entire revenue cycle to this company. If they don’t conduct employee background checks, you risk having unscrupulous individuals make off with your PHI.”

According to Sacopulos, billing, collection, and medical re-
cord departments and companies are ripe for infiltration by unsavory characters. This is because they have easy access to valuable identity theft information: date of birth, Social Security number, and photo identification. “Bank records are sold for $3 per person on the black market and medical records sell for $50,” Sacopulos said.

A billing clerk at Louisiana State University (LSU) Health System in Baton Rouge, La., copied and sold PHI for years before anyone caught wind of it. The Secret Service called LSU after the local sheriff’s wife’s identity was stolen. Investigators traced the theft back to the health system and found she was one of many victims. The crime ring reached into more than a dozen states, all fueled by a billing clerk in Baton Rouge.

“If a billing company employee mishandles your PHI, they are liable. But, so are you,” Sacopulos said. HIPAA business associate training should be a requirement; ask to see the billing company’s employee training records and policies.

If a company uses subcontractors (individuals or companies), verify that each has signed a BAA with the billing company and is held to the same standard as employees. “It can make sense from a business perspective for a subcontractor to outsource part of the work load,” Sacopulos explained. “Ask to be notified when outsourced deals are made, so you can make sure their practices are up to your company’s standards.” One way to do this is to check if a BAA has been signed with the subcontractor.

It’s OK for billing companies and practices to allow telecommuting, as long as the home office environment follows the identical security and privacy policies your practice does.

“All home-based workers must understand security and privacy requirements,” Brewer said. “We find that staff and physicians in our client offices often access PHI from the same home computers that they allow their kids to play games on. Or, they access the practice’s network via unencrypted wireless network.” Both put PHI at risk.

Brewer uses a checklist with his client’s home-based employees and subcontractors (see the “HIPAA Checklist Audit” at http://hipaaudit.com/hipaa-checklist-audit/ for information and training material). “They mark off all the measures they’ve taken in the home office, and sign off that they are operating in a way the practice requires,” Brewer said. Although HIPAA does not require this level of scrutiny yet, it’s good business practice.

Stop Using Email, Start Encrypting Access

“If a billing company tells you they communicate with clients by email, that’s a red flag,” warned Brewer.

In years past, email communication may have been acceptable, with the right policies and caveats, but with meaningful use stage II looming, secure messaging will be required soon. Practices should quickly move toward it. Bottom line: “No emailing of PHI. Ever,” said Brewer.

“Secure messaging requires an ID and password and is sent over an encrypted channel. Email is sent over the public Internet,” Brewer explained. “The service contract or BAA should clarify how the company will secure transmit and handle data when it is accessed from the billing location.” He also suggests changing expectations by changing terminology. For example, Brewer said, “Never say, ‘we’ll email you.’ ‘We’ll secure message you’ is better.”

The best way to access, share, and transmit data is through an encrypted protected electronic health record (EHR) portal. That way, all information is transmitted from one repository. It’s the most practical way to minimize step and manual cutting and pasting, both of which can be risky. Any opportunity for someone to “forget” to complete a step is an opportunity that critical data doesn’t get into the patient’s record.

If the EHR is cloud-based, the billing company should be issued a unique account for each employee and subcontractor who will access data. If not, “set up a virtual private network (VPN) for them to access your network securely,” advised Brewer.
The new BAA may seem burdensome, but it’s really an excellent risk reduction and business management tool.

These are the only two acceptable options for access, according to Brewer and Sacopulos. If you don’t use encrypted sign-on or a VPN, the only other option is to go analog. “Or, you could have someone from the billing company come to your practice once or twice a week and enter data on-site,” said Brewer. “But that’s not very efficient.”

**Move from Tacit to Explicit**

Sacopulos finds two clauses frequently missing in a billing company’s BAA: indemnification and insurance coverage. The HIPAA Omnibus Rule also requires business associates to have a breach policy and procedure.

Sacopulos explained, “If the billing company submits unintended, fraudulent billing, if they miscode or perform poor work on your behalf, your practice needs to be ‘indemnified’ of the wrong doing.” An indemnification clause holds the practice “harmless” from these types of mistakes.

Insurance coverage is another must-have for any billing company. If the company has a security breach and all your patient records have been hacked, where will the money come from to pay for the breach communications, potential lawsuits, and other restitution activities? Sacopulos recommends “practices must insist on both general liability and errors and omissions coverage.” As for policy limits, it depends on the practice’s business volume. But generally speaking, Sacopulos recommends coverage of $1 million or more for each policy.

A breach policy and procedure must also now be included in your billing company’s BAA. Make sure it includes specific details about internal and external documentation, notification, and timelines, the investigation process, and ongoing risk assessments to decrease future breach risk.

**Be Prepared for a Potential Breakup**

Finally, the BAA must address what happens when the relationship with the billing company ends.

“In the old paper days, physicians didn’t think too much about these issues,” said Sacopulos. “But because everything is now ‘out there’ forever, you must insist on termination policies and procedures that protect sensitive digital data.”

An obstetric/gynecology group of two in the Midwest turned over their billing to the practice administrator’s relative’s neighbor, who had just started a billing company. “The person was very responsible, very likeable—a real go-getter,” Sacopulos said. The problem was, she had no experience with physician billing, and she became overwhelmed by the claim volume. Claims were rejected. Accounts receivable climbed. “By the time the practice caught on, she had made a total mess.”

In any case, you must have clear procedures that outline how you get your data back; how all instances of your PHI will be returned and/or destroyed; and that access to your systems will be disabled.

“The procedure should include activities such as disabling accounts, passwords, and any access the vendor has with your systems,” advised Brewer.

“Make sure there are clear details about how the vendor will deal with PHI,” Sacopulos added. “How will it be returned to the practice? Encrypted transmission? Digital media storage devices such as flash drives, hard drives, or CD-ROMs? How will the billing company destroy all incidences of your PHI: on paper, electronic media, and removable media? All this must be clarified in the BAA.” There also should be a clear plan for informing patients and a process for transferring the revenue cycle process to a subsequent vendor.

The new BAA may seem burdensome, but it’s really an excellent risk reduction and business management tool. Instead of resisting the rigor of reviewing existing BAA terms with your billing company, use the HIPAA Omnibus Rule as a golden opportunity to evaluate them and other vendors at a more granular level to ensure your patient and financial information are in good hands.

Cheryl Toth, MBA, is a consultant and writer with Chicago-based KarenZupko & Associates. She brings 20 years of consulting, management, training, software product, and executive management experience to her projects.
Business Associate Evaluation Checklist

Use this checklist to ensure your billing company and other business associates with whom you share PHI meet the new BAA requirements in the HIPAA Omnibus Rule. Do not sign the agreement or share PHI until all issues on this checklist have been resolved.

Employees and Subcontractors

- Do you conduct (or use a service to conduct) a background check on every new employee?
- Have all employees completed initial HIPAA business associate training?
- Have all employees of more than one year completed annual refresher training?
- Does your company use subcontractors? If yes:
  - Has each contractor signed a BAA that complies with the same requirements?
  - Has each contractor completed initial HIPAA business associate training and refresher training after one year?
- Do you have either employees or subcontractors who telecommute? If yes:
  - Has each contractor’s home environment and network been audited to ensure privacy and security standards are met?

Data Security

- Do you use a secure messaging system? If yes, which software is used? If no, how do you communicate with and transmit PHI to clients?
- If you download information from the practice’s system, is it encrypted during data transmission? If it's stored on removable or temporary storage devices, how are these accessed, stored, protected, and destroyed when no longer needed?
- How often is electronic data backed up? Is it taken off site and, if so, is it encrypted when this occurs?
- How is printed PHI stored, transferred, maintained, and disposed of? Who has access?
- In the event our relationship is terminated, what is the process for returning our data and then destroying all instances of it within your company? Provide the process for data on paper, Internet, all types of removable storage media, and digital copies.

Privacy

- Have all employees and contractors been supplied with screensavers/privacy screens?
- Does your system automatically log people off after approximately 10 minutes, and require a password to regain access?
- Have all employees and contractors been trained on your HIPAA privacy policy? When was your BAA last updated?

Make Sure the BAA Contains These Essential Clauses

- Indemnification clause
- General liability and errors and omissions insurance coverage, each with a coverage limit of at least $1 million
- Breach notification procedure
- Data security policy
- Privacy policy
- Secure messaging policy and procedure, including specifics of how the vendor will communicate digitally with the practice
- Procedure for returning PHI to the practice at the termination of the agreement, and destroying all incidences of digital and paper records; procedure for disabling billing company employee access to your system
“Compliance” Is Not a Dirty Word

By Evan M. Gwilliam, DC, CPC, CPC-I, CCPC, CPMA, NCICS, CCCPC, MCS-P

Takeaways:

- Office compliance plans are mandatory under the Affordable Care Act.
- Devise a plan before you need it.
- Remember that a compliance plan is a living document that must be updated and used.

In October 2000, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) published in the Federal Register general guidelines for healthcare facilities to set up a compliance program. Busy practice managers and providers have long pushed this advice to the wayside, but now the Affordable Care Act has made office compliance plans mandatory as a condition of Medicare enrollment. Although there’s little enforcement of this mandatory requirement at this time, private payers will soon require such a plan as a condition of participation in their networks. This means a compliance plan has become a necessary part of doing business in healthcare. Although a compliance program doesn’t guarantee an office will never violate any regulations, federal agencies will consider a plan as a mitigating factor in an investigation.

Take Advantage of a Compliance Plan

A compliance plan is somewhat complex and requires familiarity with many guidelines and regulations; however, it actually can increase the operational efficiency of a practice. For example, it provides protection from complications associated with doing business with health insurance companies. If a violation were found, it could prevent massive refunds to payers, or even criminal sanctions. And if an employee understands the procedures and policies for overpayment, he or she is more likely to resolve an issue internally, rather than become...
A compliance plan simply asks providers to stay ethical and legal in all they do, which is not an unreasonable expectation.

**Compliance Basics**
A compliance plan addresses issues with:
- Centers for Medicare & Medicaid Services (CMS) guidelines
- OIG Work Plan
- Health Insurance Portability and Accountability Act (HIPAA) privacy and security
- Occupational Safety and Health Administration (OSHA)
- Clinical Laboratory Improvement Amendments (CLIA)
- National Committee for Quality Assurance (NCQA) guidelines
- Stark laws (I, II, and III)
- Anti-kickback laws
- State laws

Per the OIG, a compliance plan should include seven core elements:
1. Implementing written policies
2. Designating a compliance officer
3. Conducting comprehensive training and education
4. Developing accessible lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and taking corrective actions

**Prepare, or Risk Being Prey**
Medicare administrative contractors (MAC) are increasing their efforts to identify fraud and abuse. For example, probe reviews, which include review of a small number of records, have become very common in chiropractic offices around the country. If errors are identified, this can lead to an expanded post-payment review. Contractors have also issued comparative billing reports, which tell providers how they compare to their peers in terms of benchmarks(415,942),(995,997). Falling outside the norm on these reviews should serve as a wake-up call to improve compliance-related activities.

Recovery audit contractors (RACs) also have increased efforts to review claims before payment is made. According to a CMS report to the Office of Management and Budget, RACs look for "dramatic change in the frequency of use, high cost, high risk prone areas, or unexplained increases in volume when compared to historical or peer trends." RACs use statistical analysis by comparing provider services to the Medicare bell curve, which is unique to each specialty. Providers need not match this bell curve perfectly; they simply must demonstrate the medical necessity of services that fall outside of the norm.

It’s important to note that RACs are paid on commission. If they don’t find a reason to ask for money back, they don’t get paid. There is a high incentive for them to find fraud or other improprieties. In fact, this type of work is very lucrative; for every dollar spent on audits, $17 is recovered. This is far better than investment in the stock market, or even real estate (before the bubble popped). Consequently, rumor has it that investigator and regulator employment is increasing.

**Build a Good Defense with Knowledge**
The first way to protect yourself is by reviewing Medicare policies and procedures. The Medicare coverage database (www.cms.gov/medicare-coverage-database) provides access to national coverage determinations (NCDs), local coverage determinations (LCDs), and related articles—enough to occupy the most tenacious of compliance officers. Many agencies offer online training from those who have waded through these materials. Such training may double up as continuing education units for certification maintenance.

Articles provided by individual MACs can provide insight into particularly complex or confusing guidelines. The Medicare Benefit Policy Manual is also a valuable resource. For example, the Medicare LCD for Noridian on physical therapy services clearly outlines the documentation criteria for CPT® 97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to
One of the most important pieces of a compliance plan is internal monitoring and auditing.

Make and Implement Your Compliance Plan

The next step is to implement an office compliance plan—as soon as possible. The starting point would be the OIG website (http://oig.hhs.gov). Links to guidelines for multiple segments of the healthcare industry can be found via a search for “compliance guidance.” The document dated Oct. 5, 2000 is for small group physician practices. Unfortunately, it’s 19 pages, three columns wide, eight-point font, and written in “government-ease.” CMS released a compliance program guidance document in March 2005, which is a little briefer and easier to read. Tricare offers a free template for “medical treatment facilities.”

Establishing a compliance plan from scratch also includes reviewing the physical layout of your office or facility, HIPAA manual and procedures, the OSHA manual and exposure plan, office policies and procedures, and job descriptions. The easiest way to do this is to hire a consultant with a compliance certification, and possibly an attorney. He or she will likely use the same materials and guidelines referenced above. Numerous free compliance plan templates are available online—but remember, you get what you pay for.

One of the most important pieces of a compliance plan is internal monitoring and auditing. CMS expects practices to perform voluntary self-audits at a minimum of once each year. Use certified auditors or compli-
Auditing/Compliance: Plan

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

Customize, Follow, and Update Your Plan

There is no cookie cutter plan. It must be customized for each office and, depending upon the size of the practice, may require a full-time individual or a contractor with expertise to maintain the program. The result will be a clinic that does business more efficiently and without fear of non-compliance. It isn’t enough to simply create a binder full of text that has never been read. Your compliance plan is a living document that must be followed and updated on a regular basis. Otherwise, it’s considered invalid.

Compliance is not a dirty word; it’s the opposite. It makes an office cleaner, and it’s now mandatory by the Affordable Care Act. Just like you need a driver’s license to be out on the roads, medical practices need a compliance plan to do business.

Note: A great source for building a compliance plan and for Medicare compliance updates in the chiropractic field is www.ChiroMedicare.net.

Evan M. Gwilliam, DC, CPC, CPC-I, CCPC, CPMA, NCICS, CCCPC, MCS-P, is a physician and medical compliance specialist, and is the director of education and consulting for the ChiroCode Institute. Gwilliam is a member of the Provo, Utah local chapter. He can be reached at DrG@ChiroCode.com.
Quick Tips for Being an Effective Coding Teacher

At the end of each semester, I am overwhelmed with affection and thank you cards from my coding students. This semester, I even received a bag of homemade chocolate chip cookies. It’s wonderful to receive such expressions of appreciation, which make it easy for me to believe I’m a good teacher. Realistically, though, likability is not one of my goals. The way I see it, an effective coding instructor should strive to achieve three goals:

1. Make sure students clearly understand coding guidelines.
2. Teach students to apply coding guidelines to scenarios. Encourage students to think deeply about the information and how they will use the material on the job and during testing.
3. Set an example by maintaining your own coding certifications and having a passion for the industry.

Some may argue another more imperative objective is for students to pass the AAPC certification exam, but I do not agree.

Don’t Base Your Effectiveness on Final Scores—Huh?!

All students are not created equal. Some students may have medical work histories; other students may learn more quickly than others; and some students may be more determined to succeed than others. If a student does not pass the exam, does that mean you were ineffective as an instructor? Not at all.

Do not base your effectiveness as a teacher on final exam scores. You are effective if your students are wiser from your teaching. If you provided knowledge to the students, demonstrated how the knowledge should be applied to coding scenarios, and set an example for the students, you have fulfilled your goals. Beyond that, passing the exam is the students’ responsibility.

Keep Your Eyes on the Ball

With the pressure off as to whether your students pass or fail, you can focus on your objectives. Here are some tips to help you achieve your goals:

Keep it simple: Coding can be very complicated. Strive not to clutter your teaching with unnecessary facts. Read the key points from the text only. Talking a lot does not mean you’re teaching a lot.

Use illustrations: Illustrations can be very helpful in coding. For example, consider using illustrations when teaching procedures related to the heart or to skin flaps.

Ask questions: Ask questions that require your students to contemplate the material.

Appeal to your students: Students have different learning styles (e.g., visual learning vs. hands-on learning, etc.). Present the material in a way that will appeal to the students who are struggling.

Use AAPC curriculum: Certified Professional Coder–Instructor (CPC-I) licensees can use the curriculum provided by AAPC. Be sure to study the material yourself so you can explain the material to your students with confidence. Remember to use the AAPC instructor forum when you’re in need of assistance.

In achieving your goals, you can rest assured that you have done your best to prepare your students for the certification exam. Beyond that, wish them well, and enjoy the fruits of your labor.

Geanetta Johnson Agbona CPC, CPC-I, CBCS, is a medical coding instructor at South Piedmont Community College in Monroe, N.C. She co-owns CGS Billing Service with her spouse, Charles Agbona, and is a member of the Monroe local chapter. You can read her blog at www.cgsbillingservice.blogspot.com.
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Discover Hidden Treasures in Your Practice

ICD-10-CM is an opportunity for your practice to find new coding gems.

Nearly every white paper and article written about ICD-10-CM preparedness suggests increasing coding staff. But not every practice—particularly a small practice—can afford to hire seasoned coders. To complicate matters, nationally there are not enough experienced coders to meet the demand. Almost any practice (particularly a growing practice) might do better to look for potential coding "gems" and to create a positive work environment that encourages career advancement.

Passionate “Newbies” are Gems in the Making

My coding career began in at the University of Texas Health Science Center (UTHealth). I later transitioned into the U.S. Department of Defense world of coding at Nellis Air Force Base with Science Applications International Corporation. Now, I am back at UTHealth as manager of revenue cycle for the Department of Surgery. In my 27-year coding career, I have successfully recruited and employed several “newbies.” Some were newly certified with no previous job history, and some had minimal experience, but were not certified. In all cases, these individuals excelled beyond my expectations and are now highly respected certified coders.

Find a Diamond in the Rough

The best way to find a “diamond in the rough” is to look for someone eager and hungry to learn. Think back to when you were a new coder. Remember how excited and passionate you were about coding, and how you aspired to someday become a coding guru?

What you needed more than anything else was for someone to give you an opportunity to get your foot in the door. Now that you’ve succeeded, it’s your turn to open doors.

For example, consider my most recent new hire: She came to me seeking a summer internship in hopes of gaining on-the-job experience. She was a Certified Professional Coder–Apprentice (CPC-A®) who had just completed a local community college course in coding. I sensed her capabilities—her hunger and passion for coding—from the moment we met.

In her previous life, this CPC-A® was a court reporter and had decided to switch to a coding career. It may seem like the two professions are unrelated, but I found a common thread between the two:

- Court reporters sit quietly, never show emotion, intently listen, and
Naiveté is a treasure to coding because newbies are not afraid to ask, “Why do you do it this way?”

capture words that could be the catalyst for a life or death decision made by a jury.

❖ Coders sit quietly for hours on end, intently review medical documentation, accurately assign ICD-9-CM and CPT® codes, and assess coding that could be the catalyst for a case of fraud and abuse.

I knew I had discovered a potential gem. I did not bring the CPC-A® on as a summer intern; I hired her as a full-time coder.

Polish Your Newfound Gem
I invested time and provided a positive work environment for the CPC-A® to grow her skills. I knew it would be a challenge for her and the coder I paired her with to get her up to speed, but both embraced it. The CPC-A® learned our system eagerly; and I’m happy (and yet ashamed) to say, she taught us all a thing or two. It’s easy to become complacent when you’ve been doing something for a long time, but our newbie was on top of the latest coding guidelines, and she served as “new blood” to revitalize our own coding.

Foster Fresh Coding Perspectives
New blood can also bring fresh ideas and perspectives to old problems, and new enthusiasm can be infectious. Naiveté is a treasure to coding because newbies are not afraid to ask, “Why do you do it this way?” This innocent question forces the seasoned coder to think back to his or her roots and say, “That’s a good point. Why do we do it this way?” This prompts a productive coding conversation.

New coders also have no bad habits to break, only good habits to learn. You don’t have to un-train them on the paradigms they’ve put in place somewhere else. And when it comes to ICD-10-CM, in many ways newbies have an advantage over seasoned coders.

Unlock the True Potential
You may argue that the cost of hiring someone with no experience is prohibitive, but I hope I’ve given you reason to reconsider, and to start looking for new coding gems to enhance your coding team and to conquer the hurdles of ICD-10-CM. There are many diamonds in the rough with a CPC-A® waiting to be discovered. Recognize their potential, foster growth, and let them shine.

Koressa Gregory, CPC, has more than 27 years experience as a coder, auditor, and revenue manager. She is a manager in the Revenue Cycle for the Department of Surgery at the University of Texas Health Science Center in Houston, Texas. She is a member of the Pearland local chapter.
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Newly Credentialed Members

August 2013

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A&P Quiz (from page 22)

Answer: Correct answer is C. Four or more acute episodes per year makes the condition recurrent acute.
Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.

I was “forced” into this career after a couple of post-9/11 layoffs. I worked as a travel counselor, but after my second layoff, I decided to try something new. I enrolled in a medical billing and coding course at a local school, which turned out to be one of the best decisions I ever made. After I completed an externship at a local chiropractic and pain management clinic, I was hired there as an insurance specialist. I was quickly promoted to practice administrator. Two years later, I began teaching billing and coding part time for a local college. In 2008, I was hired as a coding specialist for a consulting firm specializing in risk adjustment/hierarchical condition categories. I was promoted to a coding auditor a year later, which provided me with the opportunity to travel to different cities. I’ve also worked remotely as an emergency department coder, and conducted online coding and health information courses. I now work as a coding supervisor for a large oncology group in the Atlanta area.

What is your involvement with your local AAPC chapter?

I am a member of the Atlanta chapter. I attend as many meetings as possible. The speakers are always well informed and the topics are very beneficial. As an instructor, the chapter was very gracious for allowing me to bring my students to meetings. It proved to be very valuable to students seeking a career in this industry.

What AAPC benefits do you like the most?

I enjoy receiving AAPC Cutting Edge and reading all the informative articles. I benefit greatly from attending chapter meetings, as well; and I’m grateful for the free and low-cost continuing education unit (CEU) opportunities.

What has been your biggest challenge as a coder?

My biggest challenge as a coder is getting providers to understand and accept coding guidelines when the guidelines conflict with their clinical knowledge.

How is your organization preparing for ICD-10?

We have a designated person to inform and direct us towards the appropriate ICD-10-CM implementation steps. This includes isolating the most-used diagnosis codes, cross-walking those codes, and examining the possible revenue loss from improper coding and poor documentation. We have checked our electronic health record for system compatibility and necessary updates. We’ve also begun the clinical documentation improvement process. This summer, I’ll begin training on ICD-10-CM coding. Once completed, I will train the coding department on the new nomenclature.

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

I would open and operate a school similar to learning academies such as the Knowledge Is Power Program (KIPP) Institute or Harlem Children’s Zone. I enjoy teaching and encouraging others, especially young people.

How do you like to spend your spare time?

In my spare time, I enjoy cooking, reading, and traveling. One of my favorite vacation spots is Destin, Fla. Anytime I can get down there I am happy! I don’t have any hobbies or other passions besides spending time with my family; I have a 14-year-old son who keeps me busy with his sport activities. I reside in a great community with wonderful neighbors and friends, and I attend services at my local church. I’m living a wonderful life!
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