Families Who Code Together Stay Together

(clockwise) Clifton L. Jones, CPC, CCP
Joyce L. Jones CPC, CPC-H, CCS-P, CPC-ASC, CNT
Traci Linn, CPC
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On the Cover: It’s no secret that the Jones family is passionate about coding. Joyce L. Jones, CPC, CPC-H, CCS-P, CPC-ASC, CNT, and husband, Clifton L. Jones, CPC, CCP, pose on their porch with daughters, Beth Wolf, BA, CPC, and Traci Linn, CPC. Cover photo by Neil Brake of Vanderbilt Medical Center.

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Vice President’s Message

Last year, our leader, Reed E. Pew, requested that the AAPC national office focus on one priority: improving our performance by delivering world class, member-focused service. Our talented and committed department heads stepped up to the plate and augmented our service staff by recruiting health care professionals. Now, we are delighted that many of our staff members are also CPCs®. The result of our focus is improved service quality, including: improved telephone hold times, faster service through better technology and staff training, and increased overall member satisfaction levels through personalized service. We continue to improve our service. We have aggressively expanded your member benefits to provide you with increased membership value, by providing the following:

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I’ve been a CPC® for 11 years and your vice president of member service for almost a year and a half. Like many of you, I’ve seen a sharp and positive turn in what it means to be a CPC® today. I believe we have made the right kind of changes in our member service, and I am proud to say we have grown into the nation’s largest member organization for professional coders, leading our industry in providing quality education and training programs, and valuable certifications.

To move forward and help our members compete in today’s rapidly evolving business environment, we’ve added member services focused on providing time-friendly education and training. We’ve created many new “on-demand” tools to help members file and log CEUs with the CEUTracker, and to register for workshops and exams instantly. CEUs earned from AAPC’s live and audio workshop exercises, Coding Edge, and EdgeBlast emails are now available online instantly graded and automatically populated for credit in the AAPC CEUTracker. We added interactive online practice exams for members to test their areas of strength and weakness before committing to a certification examination date.

Our members represent some of the finest coders in the industry and deserve the best there is to offer. In this time of positive change and ongoing improvement, we will continue to look for services that support high standards of accuracy and productivity, and give our members a competitive edge. Most importantly, we continue to look for every opportunity to provide world class, member focused service.

As we enter the summer of 2008, the AAPC stands tall with a highly qualified staff of talented individuals with your needs our top priority. Our commitment to service means your interactions with us are based on value, superior service, and a positive experience. Please feel free to contact me directly by calling 800-626-2633 to let me know how we are doing and how we can continue to best serve you!

Sincerely,

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

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Recently, my five-year-old granddaughter reminded me of what a magical time childhood is. She is an energetic and beautiful little darling, filled with light and promise. She believes she is a princess and believes in fairy tales—what child doesn’t? At one time or another we have wished for a fairy godmother to wave her magic wand and grant our wishes upon request. To be a child again and believe in fairy tales is wishful thinking that may not be far from the truth.

We see lucky people: not just people who win reality game shows or the lottery, but those who seem to glide from one success in life to another. We know lucky people: not just the wealthy, but the blessed, healthy, happy, fortunate people who seem content in whatever they do. Nothing seems to go awry in their life. What’s their secret? What if we could have a fairy godmother wave a magic wand and our lives would be perfect like their lives?

Back to reality: our lives are filled with trials and tribulations. Although, we are surrounded by daily struggles, we all have a little of that fairy tale magic in us. Every one has the ability and power to grant their own wishes. The energy we use to grant our wishes is not magic or mysterious; it is a vital part of who we are. The Universal Law of Attraction is a way to realize our hidden potential by making things happen and creating magic. There are powerful forces within us that shape and form our life experiences in the world.

Finish this sentence: “To fulfill my potential I must ________.” Ultimately, to fulfill one’s potential is our life-long goal. You may have all the money and power in world, but at the end of the day, you might feel like something is missing. Most of us started our careers with the “it’s just my job” mentality, but became passionate and enthusiastic along the way. It doesn’t matter if you are a coder, biller, consultant, physician, attorney, etc., it is the passion and possibilities you bring into your life that is important. Once you think something is possible, set your mind in believing it, and it can happen. We live in a world of evolving possibilities. We have the potential to change our life with every decision we make, good or bad. The bad decisions are not always as bad as we think. Sometimes a bad decision or mistake is good, as a painful lesson can help us gain strength and realize possibilities.

Altering the way you think could change your life. Ban negative thoughts from your mind and reach for positive thoughts. Positive thoughts attract positive experiences. Focus on the good things in life whether personal or professional. You may realize what you thought you wanted, is not really what you wanted at all.

When I was a child, I used the word “can’t” quite often; for example, I can’t tie my shoe, I can’t eat my broccoli, I can’t understand this math problem, etc. One day, my father had enough with the word “can’t.” My father scolded me and said, “Can’t never did anything.” My father scolded me and said, “Can’t never did anything, and that horrible word is banned from our home.” That day has stuck in my mind for many years. Each time I feel like things are impossible, I hear my father say “Can’t never did anything.” It strengthens me to say “I know I can.” Ralph Waldo Emerson said, “What lies behind us and what lies before us are tiny matters, compared with what lies within us and when we bring what is within out into the world, miracles happen.”

Miracles, magic, and wishes come from inside us. Unlock the magic in you and realize the wonderful possibilities.

Until next month …
An Advanced Beneficiary Notice of Non-coverage (ABN) is a form for Medicare beneficiaries to notify them that Medicare is not likely to cover specific services. It is not used for Medicare Choice beneficiaries or non-Medicare patients. A new form, CMS-R-131, was created to blend together former ABN-L and ABN-G forms. The form contains several new fields, including cost estimate, and must be used by providers no later than Sept. 1, 2008.

What Does an ABN Do?
The ABN serves two purposes:

- It encourages Medicare beneficiaries to make informed consumer decisions about their medical care. It provides beneficiaries the chance to opt out of non-covered services and informs them of their financial responsibility should Medicare deny payment.
- It shifts payment responsibility from the provider to the patient. Delivering an ABN-covered service without a signed ABN and appropriate modifier will cause Medicare to deny the services as the provider responsibility (PR) aka a write-off. Obtaining the ABN and billing the line item with modifier GA Waiver of liability statement on file generates a PR denial which allows the patient to be billed and lists the charge as their responsibility on their OWN copy of the Explanation of Medicare Benefits.

How is it Delivered?
CMS is very clear about how and when to deliver an ABN.

1. Verbally review the ABN with the beneficiary or their representative and answer any questions before the ABN is signed.
2. Do not change the ABN forms from the Office of Management and Budget (OMB)-approved format except for where allowed by customizable fields. OMB-approved forms are available at: www.cms.hhs.gov/BNI.
3. Deliver an ABN with enough time before the service rendered for the beneficiary to consider and make an informed consumer decision.
4. Never use ABNs in emergency or urgent care situations.
5. Reproduce ABNs on a single page.
6. Complete all blanks, including estimated cost, and the patient’s signature. Give a copy of the form to the beneficiary and retain the original in the patient’s file.

What Reasons Should I Put on an ABN?
Clearly state on the ABN why Medicare may not pay for the services. Reasons may include (but are not limited to) the following:
- Medicare does not pay for these tests for your condition
- Medicare does not pay for these tests as often as this (denied as too frequent)
- Medicare does not pay for experimental or research use tests
- Medicare does not consider these services to be reasonable or medically necessary

Modifier GA and ABNs
Use modifier GA to report a waiver of liability, or ABN, on file. Append GA to the line item which the beneficiary signs for EVERY TIME an ABN is signed. Failure to do so, results in Medicare inappropriately determining PR (write off) for the denied charge.

If the modifier GA is present, Medicare notifies the patient of their financial responsibility and the provider can legally bill the beneficiary for the balance due.

More Information:
If a patient needs help understanding the ABN process, the new ABN form includes the telephone number 1-800-MEDICARE under the “additional information” section. Providers can find a complete guide, including CMS instructions and forms, at: www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage

Belinda S. Frisch, CPC, is author of Correct Coding for Medicare, Compliance, and Reimbursement, and resides in upstate New York. She can be reached at BFrischCPC@nycap.rr.com.
PT Coding
Sometimes Requires a Group Hug
Brad Ericson, CPC, CPC-ORTHO

Once a patient is evaluated by a physical therapist (PT), reporting outpatient therapy can become sticky. The reason is twofold: PT modality coding is largely based on 15 minute units, and a patient might receive a mix and match of massage, gait training, and myofascial release in the same hour. The other reason is that therapists sometimes treat patients individually and in a group at the same time.

Mixed Patients Add Complexity
When do you charge for the modality separately and when do you charge group therapy? The AMA CPT® code 97150 Therapeutic procedures(s), group (2 or more individuals) can be reported for each member of a group. AMA guidelines for code 97150 say “Group therapy procedures involve constant attendance of the physician or therapist, but by definition require one-on-one patient contract by the physician or therapist.” The Centers for Medicare and Medicaid Services (CMS) also defines group therapy in publication 100-2, Chapter 15: 230, saying patients can be, but don’t need to be, performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact isn’t required.

Here is where the clarity ends. What happens if you have a group of Medicare patients coming in and out who are treated by the same modality during one unit of their time in the clinic by the same clinician but not at exactly the same time? And what happens if you have a bunch of patients in a therapy pool? Rarely are pool patients performing the same exercises in unison. Do you report 97150 or 97113 Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercise?

The Solution is Mixed, Too
Guidance is found thanks to the American Physical Therapy Association (APTA), which is working with CMS to additionally clarify the situation. The key is code 97150 in different situations. In one, the PT treats two or more patients whose condition or therapy has a common, unifying element. The patients might all be post-low back surgery or attending pool therapy. The clinician may provide some instruction and remain in attendance for the session for which 97150 is billed.

In another situation, however, two or more patients may not have unifying elements and receive diverse therapies, but never at the same time. The PT is in constant attendance and the patients may perform exercises developed for individual diagnoses and plans of care. They are, however, in the clinic at the same time with the same therapist, prompting the use of 97150.

Mix and Match
You can assign one-on-one codes along with the 97150 for those units when the therapist provides individual care. For example, while there are a number of patients in the facility receiving therapy following knee surgery, one patient may require neuromuscular reeducation of movement while another may require 15 minutes of gait training. In addition to 97150, the first patient would receive two units of 97112 Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities and the other would have one unit of 97116 Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing) along with 97150.

The duration of the group session for the applied code should be sufficient to ensure that professional services are provided. Because code 97150 is not broken into timed units, it can be used with other interventions provided on the same day of services, although modifiers may be required. ■
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I have come a long way from the six years I lived in Maui and Kauai, Hawaii. I knew I had an interest in the visual arts, so I explored my artistic side by creating small paintings mixed with found objects from the ocean, mostly sea urchin body pieces ground by the sand and waves to soft purples and greens.

My art always turned out looking very simple and graphic but, I didn't realize that I wanted a career in graphic arts until I moved back to Salt Lake City and went to college.

I was inspired by great design I saw that was possible for print media, particularly book interiors and book cover design. I decided this would be my focus.

One day while looking for work, the AAPC called me in for an interview. They hired me and immediately I went to work on the many books we publish. Talk about divine intervention. I had no idea that the AAPC published books when I went in for the interview. So I have been doing what I love for them ever since.

Last September, I was asked to design and layout Coding Edge. I was reluctant at first, but took on the challenge; and, with the help of the great people I work with, I think the magazine is looking and reading better than ever.

Coding Edge has come a long way since its humble beginnings of stick figure clip art and sparse articles. One of the most satisfying aspects of editorial design to me is solving the magazine’s problems every month. My job is to visually present the article so you know what the article is about before you read it. This is challenging when you think of the often dry subject matter of the medical coding world. I solve a problem one article at a time, giving each piece a distinct personality, which I hope draws you into it.

How do you spend your spare time?
I really enjoy being outdoors. If I had my way, I would be on a permanent camping trip, traveling the western United States: exploring, rock climbing, and hiking with my boyfriend. Unfortunately, I have little time so I often settle for a movie or a night out with friends.

If you could do any other job what would it be?
I’ve always wanted to be a garden designer. I’ve never been more at peace than when I’m in a beautiful garden.
How Do You Interpret the Fifth Commandment?

Dear Coding Edge,

I disagree with a portion of the article “The Ten Commandments of E/M Coding” by Dr. Stephen Spain. Dr. Spain’s Commandment Five is headlined by the title “Medical Decision Making (MDM) Must Match Service Level.” This is wrong for three important reasons.

1. Dr. Spain appears to draw a strict parallel between “medical necessity” and “medical decision making” in his explanation referring to the Medicare Claims Processing Manual, Chapter 12, Section 30.6.1 (page 31). I don’t think his interpretation is substantiated by any CMS literature that I have come across. These two are related, but are definitely not the same. Nor should one be substituted for the other. Dr. Spain’s article implies that MDM somehow carries more weight than the other two components, which it does not, according to the guidelines.

2. Secondly, CMS uses the term “overarching criterion for payment” when describing medical necessity. But it also goes on to say “in addition to the individual requirements of the CPT® code.” Dr. Spain indicates this CMS guidance supports his claim that the MDM must match the level of service, which it again does not. CMS’s guidance also states that the “volume” or sheer quantity of documentation should not be the primary influence on the level of service chosen. Volume doesn’t equate to the qualitative character of the documentation (where the elements go in an audit form). CMS is simply stating here that the totality of verbiage should not be reason to code a level of service higher than what is appropriate. This means the criteria for establishing the level of service should be the type of elements included, not the number of elements, further supporting that the three documentation components (history, exam, MDM) should be the driving criteria for assigning level of service. MDM alone does not drive that level of service, even though it might help steer the physician during the visit.

3. Finally, CPT®/AMA is clear in the CPT® 2008 (pages 10-11) on how to assign an established patient level of service. Under these guidelines, the MDM need not match the overall level of service. The guidelines, as listed under each code, state that only two of the three components need support the level billed. Nowhere do I find a rule indicating the MDM component should match the overall level of service. These guidelines alone contrast with Dr. Spain’s article.

To sum it all up: The level of service warranted does not solely rely on just the MDM or the medical necessity in any way under the current guidelines, and to state as such in a national publication is largely misguided. Rather, each level of service is determined by the three E/M components which in turn should be driven by the appropriateness of those services rendered (medical necessity), according to the patient’s condition.

Dr. Spain defers to the individual Medicare intermediary’s criteria for the evaluation of MDM levels. But then why print this as a concrete rule if that is the eventual course of action coders are to take? I believe the AAPC and the Coding Edge should heavily consider publishing an additional article in an upcoming issue that clarifies this concept. Not doing so has the potential consequence of steering many members, including providers, in the wrong direction when both are documenting and/or coding their respective services going forward.

Troy Bagnall, CPC

Dear Mr. Bagnall,

Unfortunately, you are not alone in following this logic, as I frequently encounter providers who exploit this argument as a loophole in the E/M coding system. Whether two or three elements are needed to determine the level of service, the 2008 CPT® manual says the components “must meet or exceed the stated requirements to qualify for a particular level of E/M service.” Using the CPT® manual instructions, by default, whenever MDM is one of the required ele-

Letters to the Editor
ments, it must meet or exceed the level appropriate for the billed level of service. Since you quoted the CPT® manual in support of your argument, I will assume that you will rely upon it as an authoritative source in this regard.

Having dispensed with any situation where MDM is used to determine the level of service, let’s turn to the circumstances where you say necessity (or MDM) does not play a role. As you stated, your argument would only apply for the subset of established patients where the provider or coder is relying upon the History and Exam elements to rationalize the billed level of service. As I understand your reasoning, it is your opinion that, in this circumstance, MDM or medical necessity does not come into play. However, this is simply not the case.

Let’s use Medicare as the model. As stated in the Medicare Provider’s Manual, medical necessity is the overarching criterion for all payment. This is not just Medicare Policy, it is the law (section 1862(a)(1)(A) of the Social Security Act). Calculation of MDM is a tool used by providers and payers to quantify medical necessity. On Medicare’s end, a medical necessity test is applied to every claim, even if the submitter of the claim is relying on only the history and exam portions (remember, the law that charters the Medicare and Medicaid programs requires them to apply a medical necessity test to every payment they make). If you look at the “bullets” Medicare uses to assess the medical necessity of a service, you will see that they match, almost completely, the components used to assess MDM.

You should read an article that appeared recently in the AAFP Family Practice Management Journal written by Robert Edsall and Kent Moore, titled “Thinking On Paper: Guidelines for Documenting Medical Decision Making.” In the article, Dr. Pat Price, medical director for Medicare Part B in Kansas and Nebraska, is quoted as writing, “It should be the complexity of the medical decision making process and the medical problem which is the most heavily weighted factor determining the E/M service level.” In the same article, Dr. Charles Calodney, MD, who represents the American Academy of Family Practice on the AMA CPT® Advisory Committee, is quoted as saying “The carriers are well aware that a physician intent on upcoding can increase the level of the history and physical very easily. Medical decision making is something else entirely. This is where they’re going to be looking.” Dr. Eugene Winter, the medical director of Florida’s Medicare Fiscal Intermediary, First Coast Service Options, recently wrote providers that the, “medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently ‘over document’ and consequently select and bill for a higher level E/M code than medically reasonable and necessary.”

In conclusion, your assertion that MDM or the medical necessity standard does not apply to some billed services is wholly outside the realm of accepted and published opinion and policy, and would pervert the principle of providing, billing, and being paid for only those services medically necessary.

Stephen C. Spain, MD, FAAFP, CPC
sspain@docuchart.com

Dear Coding Edge Readers,
We’ll explore this controversial topic further in a future issue.
Please use the AAPC online forums at www.aapc.com/memberarea/forums/index.php to post a thread regarding Dr. Spain’s “The Ten Commandments of E/M Coding” article.

Coding Edge

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Most ICD-9-CM Changes in Decade Proposed
Centers for Medicare and Medicaid Services (CMS) announced April 15 its proposed changes to ICD-9-CM for 2009, and the number of new codes this year is the most in more than a decade. More than 330 new diagnosis codes are proposed and will be posted in an upcoming Federal Register. Included are codes classifying carcinoid tumors by site; secondary diabetes mellitus in its own category 249; more than two dozen new headache codes; retinopathy of prematurity codes by stage; pressure ulcers by stage; and newborn necrotizing enterocolitis by stage. More than a dozen codes associated with Pap smears and HPV and 25 obstetrics and gynecology codes were also added.

In addition to the 330 proposed diagnosis codes, another set of more than 120 diagnosis codes was presented in April to CMS with the request they be ‘fast tracked’ for inclusion in the new code set for 2009. The decision on whether those codes will be part of the 2009 changes will not be known until the Final Rule, expected to be published in the Federal Register, in August. Along with the new diagnosis codes more than 40 new procedure codes for inpatient reporting were proposed. All new 2009 ICD-9-CM codes will become effective Oct. 1.

Use New ABN Forms
CMS posted a revised Advanced Beneficiary Notice of Non-coverage (ABN) for use when Medicare payment denial is expected. The revised ABN is for providers (including independent laboratories), physicians, practitioners, and suppliers. This ABN replaces the existing ABN-G (form CMS-R-131G), ABN-L (form CMS-R-131L), and NEMB (form CMS-20007).

CMS allows a six-month transition period from the date of implementation, March 3, 2008, to use the revised form and instructions. Providers and suppliers should use the revised ABN (CMS-R-131) no later than Sept. 1, 2008.

For downloadable ABN forms, instructions, and FAQs, go to: www.cms.hhs.gov/BNI/02_ABNGABNL.asp

To learn more on ABNs, read the article “ABN: Shift Responsibility to Patients the Correct Way” in this issue of Coding Edge.

Expanded Ways to Participate in PQRI
On April 15, CMS announced new options under the PQRI program to make it easier to participate.

New options in the PQRI law allows CMS to offer:

- Reporting approaches that give you more options to successfully participate.
- Alternate reporting periods to allow you to begin reporting on July 1, 2008, and still receive an incentive payment (1.5 percent of allowable charges for services provided from July 1 through Dec. 31).
- More options for submitting quality measures data to CMS through a qualified, established clinical data registry, in which you may already be participating.
- Removal of the limit (cap) on your incentive for the 2008 reporting period.

For more on new PQRI reporting options, go to: www.cms.hhs.gov/PQRI/.
TOP 10 Reasons for Employers to Participate in Project Xtern

10. Receive one free audio conference each year your facility participates with the Project Xtern program.

9. Be a mentor to a new coder. We each have so much knowledge to share.

8. Evaluate the extern's work ethic prior to an employment offer.

7. Evaluate the extern's skills and abilities prior to an employment offer.

6. Decrease initial employment costs. You have 90 days to preview an extern's performance prior to making a job offer.

5. Train the extern your way. New coders are eager to learn.

4. Eliminate backlog with the use of additional staff at no extra cost.

3. Interview the candidates prior to externship placement and select the extern of your choice.

2. Select from qualified candidates in your area.

1. Eliminate recruitment costs. There is no fee to be listed as an Xtern facility.
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Stay Current with April 2008 Medicare Physician Fee Schedule Updates

by Jean Acevedo, LHRM, CPC, CHC
Just when you thought you’d understood and implemented the Medicare Physician Fee Schedule (MPFS) and HCPCS Level II updates from late last year, they’ve changed again.

These updates occur each year as the Centers for Medicare and Medicaid Services (CMS) issues technical directives to its contractors to ensure contractors implement the appropriate logic for the current year’s changes, as it clarifies the payment rules and creates new HCPCS Level II codes. These “technical directives” usually publish in the first half of the year. The April change request updates some payment files and includes new and revised codes for the Physician Quality Reporting Initiative (PQRI). While the change request is published in April, the effective date for some of the changes is retroactive to Jan. 1 according to CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 1482.

Administration of Part D-Covered Drugs/Vaccines

Since Medicare Part D (the prescription drug program) pays for certain vaccines, CMS created a HCPCS Level II code (G0377) for physicians to bill Part B for vaccine administration covered under Part D. The ability to bill Part B for a Part D covered drug no longer exists, so CMS deleted G0377 from the database effective Dec. 31. In the Tax Relief and Health Care Act of 2006, Congress modified the definition of a Part D “drug” to include its administration. CMS interpreted the act to mean the negotiated price for a Part D covered drug included the cost of administering the drug. CMS believes both the drug and its administration should be billed on one claim as a way to prevent fraudulent claims of drug administration that was never given.

The May 14, 2007, CMS Memorandum from the Medicare Drug Benefit Group states “…if a vaccine is administered out-of-network in a physician’s office, the physician would provide the vaccine and its administration and then bill the beneficiary for the entire charge, including all components. The beneficiary would, in turn, submit a paper claim to the Part D sponsor for reimbursement for both the vaccine ingredient cost and administration fee.” If a patient comes to the doctor’s office for Zostavax (a shingles vaccine), it’s expected the patient will pay out-of-pocket for both the vaccine and its administration. The practice should provide the Medicare beneficiary with a 1500 form showing charges for both the Zostavax (CPT® 90736 Zoster (shingles) vaccine, live, for subcutaneous injection) and its administration (CPT® 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)) for submission to the beneficiary’s Part D drug plan. There will be instances where the physician does not stock the vaccine and the patient picks the drug up from a pharmacy, or the pharmacy delivers the vaccine, for administration in the doctor’s office. Again, the patient is financially responsible for the physician’s vaccine administration and a 1500 form should be submitted to his or her Part D plan for reimbursement.

PQRI and Other Changes

Almost 30 new performance measurement codes are included, and some existing PQRI code descriptions were revised. The added measures expand the practitioner’s program participation, potentially earning a 1.5 percent bonus based on the practitioner’s total Medicare allowed payments during the reporting period by including measures for back pain, mammography, and others.
period by including measures for back pain, mammography, and others. A number of other CPT®
and HCPCS Level II codes were modified to reflect revised bilateral indicators, relative value unit (RVU)
revisions, or procedure status changes retroactive to Jan. 1. A number of J Codes (J7611–J7614) were
reinstated and the reinstated codes were effective for dates of service on or after April 1.

April HCPCS Level II Code Update

CMS has also published an update to the 2008 HCPCS Level II codes, MLN Matters number: MM5981. CMS
updates the HCPCS Level II codes on a quarterly basis. The April update is particularly important if your
practice or organization provides inhalation therapy with Albuterol or IVIG administration.

Effective for claims with dates of service on or after April 1 the following HCPCS Level II codes will
no longer be payable for Medicare: J7602 Albuterol, all formulations including separated isomers, inhalation
solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1
mg (Albuterol) or per 0.5 mg (Levalbuterol) and J7603 Albuterol, all formulations including separated isomers,
inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1
mg (Albuterol) or per 0.5 mg (Levalbuterol), J1751 Injection, iron dextran 165, 50 mg and J1752 Injection, iron
dextran 267, 50 mg.

In their places are the following HCPCS Level II codes:

- J7613 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
- J7614 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg
- Q4098 Injection, iron dextran, 50 mg

IVIG Administration

Along with a new HCPCS Level II code for intravenous immunoglobulin IVIG (Q4097 Injection IVIG
Privigen, 500 mg), the April update includes revised billing instructions drawn from Change Request
(CR) 5981 to ensure payment for G0332 Services for intravenous infusion of immunoglobulin prior to admin-
distration (this service is to be billed in conjunction with administration of immunoglobulin) to pay for additional
pre-administration-related services where there may be potential market issues when using Q4097.

Effective April 1, the following codes are affected:

- J1561 Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg
- J1566 Injection, immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500 mg
- J1568 Injection, immune globulin, (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
- J1569 Injection, immune globulin, (Gammagard liquid), intravenous, non-lyophilized, (e.g. liquid), 500 mg
- J1572 Injection, immune globulin, (Flebogamma), intravenous, non-lyophilized (e.g. liquid), 500 mg
Medicare contractors will only pay a claim for pre-administration-related services (G0332) associated with IVIG administration if G0332, the drug (IVIG, HCPCS codes: J1561, J1566, J1568, J1569, J1572 and/or Q4097), and the drug administration service are all billed on the same claim for the same date of service;

Returned institutional claims for G0332 to the provider:
- J1561, J1566, J1568, J1569, J1572 and/or Q4097
- A drug administration service are not also billed for the same date of service on the same claim
- Rejected professional claims as unprocessable for G0332 if J1561, J1566, J1568, J1569, J1572 and/or Q4097 and a drug administration service are not billed for the same date of service on the same claim

If you don’t follow these billing rules the claim is denied with a message such as M67 “Missing other procedure codes” or 16 “Claim/service lacks information.” The reason explanation of benefits codes often merely state something for claims adjudication was missing but don’t tell you what. In the case of IVIG billing, you should check to see if guidelines noted were followed. If not, then the specific information prompting either of these reason codes will be apparent.

For more changes, check out Change Request (CR) 5980, issued to your carrier, FI, and A/B MAC which may be viewed at www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf on the CMS website. And, the April HCPCS update is found at www.cms.hhs.gov/transmittals/downloads/R1492CP.pdf.

Jean Acevedo, LHRM, CPC, CHC, President & Senior Consultant of Acevedo Consulting Incorporated, is President of the AAPC Palm Beach County chapter. She is a member of the Editorial Advisory Boards of Medical Office Billing and Collection Alert, Physical Therapy & Rehab Alert, and Internal Medicine Coding Alert, national newsletters published by The Coding Institute.
Coding Edge (CE): Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.?

Stilley: My health care career started in college working in a small town clinic where I collected urine samples, ran EKGs, and cleaned up after barium enema procedures. Soon I decided to take on a more glamorous side of medicine by performing venipuncture at the local blood plasma donor center where we processed hundreds of specimens each week. Since then, I have worked for private physicians as a medical assistant, later moving into the billing and coding side. In 1996, The University of Oklahoma, Tulsa offered me the clinic manager position for the obstetric-gynecology department where I attended a coding class under the tutelage of Gay Boughton-Barnes. After several months of taking classes, reading, attending lectures, and having study sessions over coffee, I took the CPC® test and passed it. At the time, I didn’t know about the AAPC or what a certified coder represented. I hadn’t realized the opportunities that they bring and the people that I would meet and share experiences with. I have been fortunate to have mentors to encourage me and become lifetime friends.

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

Stilley: Four years ago, I served as president. Prior to my presidency, I was responsible for our local chapter newsletter. Currently, I serve as the education officer. We have an annual fall conference where the entire chapter is involved—this is the high-point of our year!

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

Stilley: My personal experience shows that physicians really want to do the right thing: they want the best care for their patients, and they want to be available for their family. They are pulled in many different directions. Physicians rely on their staff for education regarding new codes and regulations, and they want coders to tell them when they are not “making the grade.” With that being said, I have three suggestions:

1. Be professional and courteous; earn their respect and trust.
2. Ask for a time to discuss a specific issue. If they prefer, send an email, make quick notes on a progress note, or ask for time in a staff or faculty meeting to go over tickets and errors.
3. Remember that when a provider is busy, your timing is critical!

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

Stilley: Is there a market for a person over 50 who is content watching peppers and tomatoes grow, and making salsa with them when they are ripe?

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

Stilley: I have three great kids. (I can say that now because they don’t live with me!) They blessed us with nine beautiful grandchildren. A perfect weekend is when they all come Saturday for dinner and they all go home Sunday afternoon.

In the words of, George Carlin, “Surround yourself with what you love, whether it’s family, friends, pets, keepsakes, music, plants, hobbies, whatever. Your home is your refuge.” I love planting a vegetable garden and canning the fruits of my labor, reading a good book, and watching movies that have a plot. I love the ocean—my husband and I traveled to Kauai for our 35th anniversary and we had the time of our lives.
Let’s Give Three Cheers!

Raemarie Jimenez, CPC, and Jeri Leong, RN, CPC, CPC-H, were recently highlighted in Advance for HIM’s March 24 issue as two of its Top 10 in HIM.

Raemarie received honors as Top Pathfinder for her work expanding the Project Xtern program and presenting career experience opportunities to new coders. Advance said Raemarie doubled the number of Project Xtern sites from 80 to 167. Raemarie is also responsible for the Coding Edge’s advertising.

Jeri, a former National Advisory Board (NAB) president and a tireless coding evangelist, was named Top Trailblazer for virtually establishing coding as a profession in the state of Hawaii, the only state that requires certified coders for medical bill review. Jeri began by holding chapter meetings around a kitchen table—now, the state has more than 400 members!

Kudos to you both from Coding Edge!

Kudos to Marti Geron, CPC, CMA, CM, reimbursement manager, department of pediatrics at the University of Texas, Southwestern Medical Center at Dallas, for the past 10 years. Birdette Bean, RN, CPC-I, president of the Scottsdale, Ariz. local chapter, said, “Marti has accepted a position as an auditor with the University of Texas’ billing/institutional compliance office. She was my coding instructor at the University of Texas, Arlington, and I’ll always be thankful for the coding foundation I gained in that class! Marti has been a successful reimbursement manager and coding instructor—a great accomplishment, and now I congratulate her and give her ‘Kudos’ for her newest achievement—a position as an auditor!”

If you deserve kudos, please email your accomplishments to our editors at kudos@aapc.com.

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Families Who Code Together Stay Together
by Michelle A. Dick, Senior Editor

Hoofer Sisters: Coding has kept us close, traveling, and working together

Four Texas Sisters
Toni J. Hoofer CPC, PMCC, ERCS, emergency room coder, elected to speak on behalf of the four coding sisters.

Toni started coding in 1998 after working 15 years in long term care. Toni answered an ad in the paper for a coder at a billing company. She said, “I was given a chance and, as they say, the rest is history. This billing company has at one time or another, since 1998, employed all of my sisters.” Toni became certified in 1999, and her sisters followed suit soon after: Tammy Bellamy in 2003, Tina Myers in 2004, and Terri Stone in 2005.

Toni says “We have been very blessed with the jobs we have now. We are emergency room coders and we work from home. We are employed by a company in Okla. In 2006, we moved our parents down closer to us due to health problems. Our father is on hospice because of heart problems and this has made it easier to help take care of him. This profession has helped us deal with doctors, hospital, pharmacy, etc.”

Coding Challenges
The biggest challenge in coding for the four sisters is the amount of knowledge that is needed and how it grows and changes daily. Keeping up with the
changes is exciting. Toni said, “We are all active members in the San Antonio Chapter of AAPC. Networking, attending conferences, and meeting new people has helped and we do this together.”

**Family Get-togethers**

When Toni reflects on how coding has affected her family, she said, “We have a relationship that many people are envious of—growing up in the military sometimes you only have each other. Coding has kept us close, traveling together, and working together. We have two younger brothers (not in coding), but our sister-in-law, Cindy Hoofer, was trying to decide on a career change; she studied on her own and in 2007 she passed the CPC exam in St Louis, Mo. We really do have a family affair!”

The sisters have yearly family reunions that their father started several years ago. Toni said, “Getting together is like the ‘Family Tradition,’ Hank Williams Jr. song. The conversation always comes around to coding and the other members just roll their eyes and give us a few laughs. There are many medical questions that come up and of course we have to put our two cents in.”

**We Are Family: I Got All My Sisters and Me**

Toni, when referring to her sisters’ families said, “I am the only single one in the bunch (good or bad), my spare time is with the Sci-Fi Channel and attending Red Hat meetings with friends. My sisters have husbands and grown children and pets that keep them busy. BINGO is a pasttime we all participate in with mom, and we do win. Taking care of the family is very important to all of us and our jobs have made this possible. We are truly blessed. Our parents have done a wonderful job and now it is our turn. We are a very proud family.”

Tina agrees with Toni that family is important and coding helps tie them together when she said, “My sisters and I have always been close. We all had separate careers and families, and we always stay in touch. When we all became certified and started coding together, I learned a new respect for all my sisters. We talk constantly, answer questions, just bounce things off of each other, and are never too busy to help each other. My sisters are the greatest and I can not imagine my life without them.”

After a long day at the office where all you do is live and breathe medical coding, imagine yourself plopped on the couch relaxing, feet up. You try hard to forget the E/M claims that were denied earlier today. Slowly, the denials slip from your head, and then you hear a voice say, “Did you hear that the new ICD-9-CM codes might be released?” This scenario is familiar to many AAPC members: the passion for coding doesn’t stop at the office and it has found a haven in the family household.

We interviewed four very different families with one common thread—coding. These four members tell Coding Edge how coding not only affects them, but how it affects their families. What these individuals have in common is they aren’t the only member in their families who are passionate about coding.

“In 2006, we moved our parents down closer to us due to health problems. Our father is on hospice because of heart problems and this has made it easier to help take care of him. This profession has helped us deal with doctors, hospital, pharmacy, etc.”
Beth Wolf, BA, CPC, coding consultant for HCA working with Regulatory Compliance, shares with us her coding family members’ story.

Beth’s mother, Joyce L. Jones, CPC, CPC-H, CCS-P CPC-ASC, CNT, director of business operations at AmSurg, is her family’s coding inspiration. She’s the coding inspiration for Beth; her dad, Clifton L. Jones, CPC, CCP, lead physician education specialist at Community Health Systems; and sister, Traci Linn, CPC, partner and manager of business operations at Evergreen Healthcare Solutions.

Joyce helped Beth and Traci find jobs after school. Beth worked in a coding department while Traci worked in a doctor’s office. Cliff, on the other hand, would listen to Joyce while teaching the AAPC Coding Curriculum. Before and after Joyce’s lessons, she had a long way to walk and Cliff wanted to be sure she was safe. He would sit and wait for her, and eventually, he learned how to code.

“How many times do you call your coding mentor, who in my case is my mother, and end the call with ‘I love you, see you soon!’ I’m sure when I first started working in my office, people had to think I make personal phone calls all the time, but even though I am talking to family, it really IS work related!”

Family Relationships and Coding

Coding has affected Beth’s family relationships in a positive way, as she frequently calls her mother from work with coding questions. Beth said, “How many times do you call your coding mentor, who in my case is my mother, and end the call with ‘I love you, see you soon!’ I’m sure when I first started working in my office, people had to think I make personal phone calls all the time, but even though I am talking to family, it really IS work related!”

Since there are four coders in the family, it can sometimes be difficult to have a family gathering without discussing coding. Beth said, “My dad and I made a pact a long time ago that we weren’t going to talk about coding at the dinner table, but sometimes we have to remind my mom. She just giggles when we do.”

As for how coding has affected non-coders in the family, Beth says, “I don’t think it has affected relationships with the non-coder family members. At different points, we have had uncles, aunts, cousins, etc., thinking about a career in coding—but so far, it’s just me, mom, my dad, and sister. If we get any more family involved, we will have to start our own chapter!”

Family Get-togethers

It’s easy for Beth’s family to get together for family functions as they all live relatively close to each other in the Nashville, Tenn. area. She said, “With the size of our family, we usually have a birthday or holiday to celebrate each month, as well as cookouts or bonfires. The women in my family have a tradition of making chocolate candies every Christmas. It’s a tradition we started in honor of my grandmother (my mother’s mom).”

Beth’s spare time is spent training for a half marathon. She enjoys reading, cooking, and art. She is married to her best friend, Jason. They have two cats: Belle and Max.
“Coding together as a family can actually become quite passionate, at times. Instead of playing Monopoly or Texas Hold’em like other families when they get together, I find we will often bring up the coding challenges we have encountered during the work week.”

**Mom, Dad, and Daughter**

Jo-Anne Sheehan, CPC, founder of Lomar Associates, tells us about her coding family.

Jo-Anne’s company provides medical billing, coding, and consulting services in the New England area. She has been featured in *Working Women* magazine and *National Electronic Biller’s Alliance* newsletter and has acted as a medical billing expert in highly profiled insurance fraud cases in Boston. Jo-Anne’s husband, Thomas Sheehan, DC, CPC, has had a successful chiropractic practice since 1988. He joined Jo-Anne in 1993 to help her manage her growing company, and assists employees and clients who need help in coding or billing. Tom is working with Jo-Anne as an approved AAPC “in house” vendor, training Lomar’s staff for their CPC®. Dianna Lomasney, their daughter, attended Salve Regina University and is training under her parents to be a CPC®.

**Coding: Fun for the Family**

Coding has affected Jo-Anne’s relationship with other family coders in a positive way. She said, “Coding together as a family can actually become quite passionate, at times. Instead of playing Monopoly or Texas Hold’em like other families when they get together, I find we will often bring up the coding challenges we have encountered during the work week. We then review tough operative notes together that require different approaches and solutions. Tom, my husband, is truly a teacher of anatomy and physiology, and his approach to coding strategies is based on that knowledge, where Dianna and I approach it from a coding ethics point of view: bundling and unbundling, modifier usage, insurance carrier rules, etc.”

Jo-Anne feels coding together has definitely brought her family closer. She said, “The simple fact that my husband and I relocated our businesses to be together for my staff and to work together truly says it all. I also enjoy taking a day off from the office with Dianna to attend seminars about coding. The seminars combine family time with education—lots of fun!”

**Coding May Not be for Everyone**

When referring to Jo-Anne’s non-coding family members, she said, “My son, Steven, attempted coding and billing for my company last year, but decided he liked automobiles better. He now is studying to be an automotive technician at Universal Technical Institute (UTI). He had a difficult time understanding why coding rules varied among payers. He didn’t like the fact that coding was not black and white. ‘Too many gray areas,’ he said. I have to agree with him. You either adapt and fit the mold for this job or find a different career path. His girlfriend, Jessica, now works for me and is anxiously preparing for the CPC® exam.”

Jo-Anne’s 14-year-old daughter, Mary Kate, tolerates all the coding discussions. She wants to have fun when the family gathers. If there are serious discussions to be had, they should be about Hanna Montana or the Jonas Brothers. As of right now, Mary Kate is definitely not interested in a coding career. “Of course, time will tell … Dianna wanted nothing to do with coding when she was in high-school or college but somehow she has managed to work for Lomar Associates, and she is truly my shining star!”
“We get together at family gatherings and laugh at some of the funny situations we have encountered. The rest of the family kind of looks at us like, ‘What’s so funny?’ It makes it even more fun between us.”

The Halls and Teels Family: Coding brings laughter at family gatherings

Mother and Daughter-in-law
Rena G. Hall, CPC, and Amanda Teel, CPC, share their family coding relationship

Rena fell into coding while working as a receptionist. She was offered a position in the billing and coding department in 1988. Since Rena started, she has worked many roles in the claims process. She has worked in billing and collection, coded, researched claims, and followed-up, audited, and appealed. She now bills insurance for KC Neurosurgery. Rena’s daughter-in-law, Amanda, was introduced to medical coding and billing when she worked as a unit clerk at an area hospital. She works for an insurance company in customer service, and is training in data entry, which places her closer to coding. She recalls, “When my supervisor left to work for a Medicaid HMO, she recruited me to come along and do the inpatient authorizations … the rest is history!”

Rena and Amanda both agree that coding can be a challenge. Rena said “My biggest challenge is translating the doctors’ terminology into the terminology used in the CPT® and ICD-9-CM books!” Amanda declared “I would have to agree with Rena!”

Family Relationships and Coding

As for how coding has affected their relationship, Rena said “Amanda and I have always been pretty close. This career just gives us one more thing in common.” Amanda agrees, “Rena and I have always been close, but it is nice to have someone who understands when you have had a frustrating day and why!”

When referring to the non-coders in the family’s reaction to their common passion for coding, Rena said, “They mostly hate it when we start ‘talking shop,’ but all in all, there hasn’t been any major conflict because of it.” Amanda said, “Sometimes when we ‘talk shop’ the rest of the family just looks at us as if we are speaking a foreign language!”

Talking about coding can lighten-up the atmosphere at family functions. Rena said, “We get together at family gatherings and laugh at some of the funny situations we have encountered. The rest of the family kind of looks at us like, ‘What’s so funny?’ It makes it even more fun between us.” Amanda is thankful that she married into a family where she can honestly say “I love” about her in-laws. “Not a holiday goes by that we are not all together.”

What Free Time?

Rena’s spare time is spent singing and playing handbells at her church. She enjoys taking Spanish lessons. Rena said Spanish, “Another challenge, but I thrive on challenges!” Amanda has three children who are actively involved with sports and church activities, which takes up most of her free time. Amanda said, “When I do have a free moment, I love paper crafting and quilting.” Together Rena and Amanda enjoy making flavored coffees and chocolates and sharing recipes.

Michelle A. Dick holds a BS in graphic design from Buffalo State College. She has been editor-in-chief for six graphic design tutorial publications, editor for the Coding Institute’s Part B Survival Guide, and is now engulfed in the world of medical coding.
Coding Edge received an overwhelming response to our Bulletin Board’s call for coding families. Although we couldn’t include everyone’s comments, here are some coder family stories we received from members.

More Families Who Love to Code

I had to laugh when I saw your inquiry on this month’s bulletin board regarding coding families. Mine is such that when I was pregnant with my son, my friends tried for months to get me to name him ‘Codey!’

I’ve been in the field for about 15 years now. My husband, Russell D. Skow, CPC, and I were married seven years ago, and at that time he was working as an electronics technician. Day after day, I would come home from work regaling tales of fascinating operative sessions, legal compliance challenges, and the latest on the OIG Work Plan. My husband would just look at me and roll his eyes.

A few months later, I started teaching medical coding and reimbursement at a local allied health college. I encouraged him to audit my night “Introduction to Medical Coding” course. My husband caught on quickly. I was surprised at how well he seemed to grasp the material (maybe I was just really that good of a teacher). He continued in the associate degree program (with other instructors), and went on to earn his CPC® certification shortly after.

Contrary to popular belief, we don’t sit around the dinner table every night discussing coding. We didn’t end up naming our son ‘Codey,’ or teach him numbers using CPT® codes. However, there are times, when the mood and lighting are just right, that a little HPI or ROS talk really makes an evening!

Heather J. Skow, CPC, Area Reimbursement Manager, South Region Critical Care Systems

I am a CPC®, and have two sisters-in-law in the business as well. Cynthia M. Roberts, MA, RHIA, the eldest of the three of us has a master’s degree in healthcare information management (HIM) and is an HIM director. Charlene E. Young, CCS, is the middle sister and is an inpatient coder for a university medical center. I am the youngest of the three and I work as a director of business operations for a private practice specializing in mental health for seniors.

We constantly have coding conversations at family gatherings and everyone looks at us as if we are speaking a foreign language! When the three of us get together the topics are ICD-9-CM and CPT® codes.

Angela R. Roberts, BBA, CPC

I began working in an HIM department about 12 years ago, but not in coding. Within a few months, I learned and worked in coding. I thrived in coding and in 2002 passed the CPC-H® exam. When my daughter, Melissa Tweedie, CPC-H was in high school she started volunteering at our hospital in the HIM department where she filed and pulled records. Eventually, she was hired to do part-time work while still in high school. We are very close and this brought us even closer together.

When the time came for Melissa to choose a course of study, she decided to apply at Alfred State College, in the two year health information technology/medical records associate degree online program. She was also interested in coding and decided to take the coding and reimbursement specialist certification at the same time. I had always wanted to go to college and earn a degree, but the timing was never right. Melissa convinced me that I should also enroll. We were both accepted to Alfred State College and graduated two years later. Melissa and I worked for the same HIM department full time; myself as a coder and Melissa as a HIM clerk, while pursuing degrees full time. I furthered my credentials and passed both my RHIT and CCS exams. Recently, Melissa passed the CPC-H exam.

Linda Benson, RHIT, CCS, CPC-H
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You’ll see some changes to Coding Edge in the next few months we feel will make your be a member easier and more satisfying. We’re responding to your requests for more information and better access to what you need not only to maintain your membership, but improve your stature as a coder.

Some of the changes include the following:

- **Test Yourself** is now online at www.aapc.com. Sign in to the Member Area and go to Resources. Open the Coding Edge and you’ll see electronic copies of past issues. Since April you’ve been able to complete the test on-line.
- How? Select the Test Yourself to the right of the magazine. Take the exam while reading the magazine or open the electronic copy. Search for the answers and fill in the button. If you’re wrong, you can try again until you’re correct. This helps you understand what answer coincides with each story.
- When finished with a correct test, select “Grade” and you’ll see your certificate and the CEU will be automatically posted in your CEU tracker.

Eventually, we’ll replace Test Yourself in the Coding Edge with more good information by members. You’ll still be able to take the tests and get the CEU through the Member Area on our Web site.

- **Exam Dates** Another change you’ll notice beginning with this issue is the removal of the Exam Dates. These are posted on www.aapc.com on the main page under Certification. Go to Exams and note your state. A complete list updated in real time lets you know where and how to apply for the next exam closest to you.
- The limitations of space and the magazine’s monthly schedule prevented us from bringing you all or the latest scheduled exams. We’re excited to be able to dedicate that space to another coding article, helping you do your work while the AAPC Web site helps you pursue your certifications.

We’re anxious to serve you. Please let us know what else we can do with Coding Edge to make your work a little easier, your career a little more full, and the magazine more useful.

*Brad Ericson, CPC, CPC-ORTHO*
Director of Publications
THE WORK OF A CODER:  
Survey Tells Us Who We Are

More than 12,000 of you responded in January to the Work of a Coder survey. It revealed some surprising results, further defining us as a profession and helping to debunk some stereotypes.

The survey, made available online through a Web link, was open to responses for six weeks. It garnered 12,068 respondents, of which 93.5 percent were professional coders certified through AAPC. The survey collected demographic information regarding work environment and credentials, and included 40 questions specific to work and working relationships. Completing the exam were 8,975 coders, or 74.4 percent of participants. The data aggregation engine for the survey was provided by SurveyMonkey.com.

The results found in the Members area of the AAPC Web site, were completed by coders in all walks of life. Half work in physician practices. Billing company employees comprise 11.8 percent of responses, and outpatient hospital employees, 9.8 percent. The weight of the numbers in physician practices is reflective of AAPC membership. The survey goes further into the actual tasks performed in the office. But that’s where the ho-hum part of the survey ends. Here are some of the interesting results:

- Most of those surveyed (92 percent) felt relationships between providers and payers are positive.
- Respondents like the idea of working from home, and frequently mentioned noise in the office as a problem affecting productivity. In all, 31 percent of respondents said they work at home some of the time, and 8 percent said they worked at home full-time. The highest number of telecommuters is found among billers; 39 percent work at home some of the time and 13 percent work at home full-time. Only half said professional coders review EOBs and handle appeals at their office.
- Six out of 10 said their physicians have a solid knowledge of coding and compliance, and seven out of 10 say their physicians comply with coding documentation requirements.
- Most (93 percent) say they are provided with necessary resources and that their employers pay for their CEUs (71 percent). Only 62 percent of employers pay for membership dues.
- Fifty-six percent of respondents said their physicians perform coding duties in their practice. Of those physicians who code, 71 percent do so regularly or all the time. Of those who code, three out of four do so using cheat sheets or EMR pick lists.
- Most physicians, however, don’t have formal coding education while their coders do.

This exhaustive survey by the Academy helps confirm the role of the coder while clarifying misconceptions in a profession that continues to grow and change. For a more specific look, check out the Members area of the AAPC Web site.
Quotes from the Survey

“I am very lucky. I work for a physician that understands coding and the importance of proper coding and compliance. He helps me keep informed on changes and also helps me with my education and CEUs.”

“My employer understands & appreciates the value I bring to the company. I also have taken on an unofficial role as an educator and compliance officer to inform our company about coding changes and compliance issues. I am very fortunate to be working for a company like this one.”

“In the past, they were content in coding everything as pain and only providing one Dx per claim. I have proven that by being creative and using specific Dxs and different Dxs for different tests, reimbursement for these services have increased with fewer appeals necessary. Yes, I have made a difference in their practice.”

“I love my physicians but sometimes I think that they think the coders are the bad guys because we give them back charts to dictate as well as needing more information. We don’t have the same relationship as the other administrators in our office. Everybody is laughing and having great relationships with everybody else, except for us. We have to be in an office together (3 coders) and trudge away coding, trying to make ends meet at the end of the month, while it seems like everybody else isn’t even working. The coders put in a ton of hours. Sometimes I wish I could be the one out there building relationships with the physicians to let them know that we do have a personality and that we’re not the bad guys.”

“The coding department is always the ones to blame when revenue isn’t being generated fast enough.”

“When the coders go to classes and return with information, the providers do not always accept what we have learned as accurate.”

To see this information and more, go to the Resources tab in the Members area of the AAPC Web site.

My employer pays for CEUs to keep my knowledge current. 8,414 respondents

The relationship between my practice and payers is positive. 7,073 responses
Sorting through the thousands of responses to AAPC’s The Work of a Coder survey, it is clear that coders love coding.

But for coders working in physician offices or clinics, a strong division arises between those who love coding and love their jobs, and those who love coding but are downright miserable in the workplace. How do we account for the difference?

It may boil down to something as simple as perception. Consider this analogy: We all, intellectually, appreciate the fact that our neighborhoods and our families are kept safe by police and firefighters, either of whom would risk their life to protect you from harm’s way. Emotionally, however, each creates a very different response in us.

When we think about an encounter with a police officer, what images do we conjure? We think of someone who demands that we slow down, or someone who waits to give us a ticket. The police officer is seen as an obstacle between us and our goals. He may have public safety as his goal, but to us, he’s an unwelcome enforcer.

When we think about an encounter with a firefighter, what images do we conjure? We think of someone saving a cat in a tree, or rescuing a sleeping family from a house fire. The firefighter is seen as someone who makes himself an obstacle between us and certain danger. His goal is public safety, and we look upon him as our lifesaver.

When your physician sees you heading his way, who does he see: the police officer or the firefighter? An obstacle and enforcer or a welcome lifesaver? The answer will correlate directly to your own job satisfaction.

If you are a firefighter, bravo! You’re part of a team with common goals and mutual respect. Your physician may see you as a firefighter because of your own communication skills and team-building activities, or you may be benefitting from groundwork laid by your predecessor. It’s also possible that you work for a provider who independently figured out your role. Count yourself lucky, as this survey respondent does:

“The relationship between coders and physicians is collaborative, and communication is essential to compliance and reimbursement. We are the “business side” to the medical office and we are valued as “equal partners” in the success of our practice. My employer generously provides resources and training (including conferences) for the coders in equal measure to other members of the practice (medical staff & providers).”

If you are a seen by your providers as a police officer, work to change your hat. Consider new communication tactics and work approaches. The fact that you are perceived as an enforcer is not necessarily your fault. It could be that your physician doesn’t appreciate impediments to his clinical calendar, even when they lead to higher reimbursements. Or it could be that a previous coder employee warped the physician’s view on the value of coders. What can you do to help your physician see you differently? We may find some answers if we look at the activities of firefighters:

Prevent and educate. The best fire is the one that is prevented. Work with your physician to reduce future errors by ensuring he or she understands the problem. Bring documentation or examples to illustrate your case, and keep your explanation as concise as possible.
Remember:

- **Don’t fan the flames.** Keep your voice level and unemotional. Don’t use “hot button” words like “always,” “never,” or “wrong.” Once a physician is put on the defensive, communication suffers.

- **Speak in positive tones.** Many people only point out what is wrong; be sure to praise what is right. Outline steps to improve the rest. Put dollar amounts to your suggestions to move your image from “enforcer” to “money-maker.”

**Size up the problem.** Before firefighters enter a building or climb their ladders, they assess the situation to determine which approach will be most effective. Coders seeking information from their providers should do the same. Ask neutral, introductory questions, and agree where you can. An emphatic nod accompanied by “Absolutely!” or “So true!” can get frank answers to your follow-up questions. Follow-up questions can help you sort feelings from facts. Wear down resistance with good humor and an earnest desire to fix the problem. Leave your ego at the door.

**Preserve and control.** Do what you can to diffuse the heat. The best way is to remain emotionally neutral yourself, even when faced with a confrontational doctor. Don’t respond to aggressive or angry questions with an answer. When you answer an angry question, it sends a message that the question’s tone is appropriate and you are the rightful recipient of anger. Instead, ask another question, or make a comment acknowledging the physician’s concern: “I know exactly how you feel—this is so frustrating!” Not only will this help to cool the situation, but it also results in you gaining a reputation as an even-tempered professional.

**Search and rescue.** Successful search and rescue is dependent upon devising a plan and following it through. Do your homework before each encounter with the physician team. Have copies of coding or compliance rules you plan to cite. Be organized in your written and verbal communications, and link your concerns to the “vital signs” ($$$) of the business. How is this going to safeguard the practice and increase revenues?

**Foster teamwork.** Never forget you and your physician are on the same team. Firefighters work in large teams and each player has a critical role. In teamwork, there is no right or wrong. Instead, everyone is committed to mutual success. If your language and attitude communicate self-righteousness, teamwork is doomed. A team culture in which everyone is chasing mutual goals is what you seek. Look at how everyone suffers in this survey respondent’s office:

> “I have been met with resistance and outright anger when I have asked the physicians to correct, complete or comply with whatever would be necessary to warrant the code they wish to be sent on to the insurance company. Now I just down-code the fee ticket if it is not documented it was not done.”

Many times, we make the mistake of thinking our coding abilities are enough. But it is human nature to value trust more than competence. Earn your providers’ trust, and they will see your competence. Use facts, data, and coding and compliance rules to allow your physicians to make their own analyses. Don’t feel their need to validate. The facts are a reflection of your abilities. Trust is developed over time, and they will eventually be comfortable with your presentation of the facts without having to investigate the issue themselves. When that happens, you’ll know you’ve changed hats and are a bona fide coding firefighter.
HOW TO DISSECT OPERATIVE REPORTS & FIND MISSING PIECES
Plus Important RAC Update

Learn the best approach to coding operative reports. This seminar provides you with specific techniques to abstract necessary information from complex documentation. Discover coding tools that deliver the best value and tips to help physicians improve documentation for optimal transference to correct codes. In this comprehensive and hands on seminar, you will learn an easy 10 step process for physician coding using real, redacted operative reports that represent the most complex coding scenarios. This process applies to all surgical specialties and provides you with:

• Easily Interview physicians to identify missing documentation.
• Learn about working with CACs to achieve the most accurate codes.
• Report unlisted procedures and get paid for them.
• Best practices for avoiding unbundling mistakes.
• Proper use of modifier 51 and 59 and the specialties most affected.
• Create outcomes that are correct, productive and painless.

Why you should attend: You should attend if you are a coder, biller, in the allied healthcare industry, or any part of your job involves responsibility for the physician coding or billing of surgical procedures.

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*Presenters:

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Lynn Anderanin
Bevan Erikson
Marsha Diamond
Arlene J. Smith
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<td>Liz Troutman, CPC-A</td>
<td>North Potomac MD</td>
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This worktext will allow you to answer questions right in the book, making it both a learning tool and a personalized resource.

Practice exercises are provided throughout to self-test, and procedures are illustrated to clarify concepts.


Many clinical examples are utilized throughout the text to provide “real-life” examples.

Provides a standard coding background for all medical specialties.

Clear and practical guidelines introduce job responsibilities and basic processes comprising the medical billing world.

Case studies and application tools offer practice on actual forms to build new knowledge and skills.

Learn how to code correctly and maximize reimbursement.

As Medicare pays a large percentage of health care claims, this valuable resource focuses on helping you develop the critical billing skills to execute correct reimbursement.

Once you have mastered the competencies for Medicare, you can easily transfer this knowledge to other insurance programs.

Combines ICD-9-CM, HCPCS level II and CPT coding concepts into one convenient learning package.

Presumes no prior knowledge of coding, and yet offers a level of detail suitable for both beginning and more experienced coders.

Chapters contain case studies to guide the user through the assignment of codes, and contains the most up-to-date information.

Provides the foundation you need to get your coding skills to the next level.

Learn how to abstract the right information from medical records, how to match diagnoses with the correct procedures, and when and how to use CPT modifiers.

Focuses on the use of encoder software.

Screen shots from encoder product provide visual examples throughout the text.

Exercises using the encoder software appear throughout the text.

A free trial CD-ROM of EncoderPro by Ingenix is included.

Provides a foundation you need to get your coding skills to the next level.

Learn how to abstract the right information from medical records, how to match diagnoses with the correct procedures, and when and how to use CPT modifiers.

This worktext will allow you to answer questions right in the book, making it both a learning tool and a personalized resource.

Practice exercises are provided throughout to self-test, and procedures are illustrated to clarify concepts.

Comprehensive information on the health insurance field, managed health care, legal and regulatory issues, coding systems, reimbursement methodologies, and common health insurance plans.

CD-ROM in the back allows for electronic data entry of CMS-1500 claim form information.
A Complicated Nephrectomy

In April, we presented a case of a patient presenting with acute renal failure. Her left kidney had succumbed to an arterial occlusion and was to be removed. Complicating the procedure was a difficult repair of the superior mesenteric artery, the celiac axis, and supporting tissues. We asked Nancy Reading, vice president of education at the AAPC, to take a look. Here’s her take:

First let’s look at the clinical picture. This is an interesting case physiologically. Renal blood flow (RBF) is regulated by a large number of factors to keep flow steady and in turn to keep the filtration of plasma through the glomerulus (glomerular filtration rate or GFR) steady. Remember blood flows into the kidney through the renal artery and then the plasma portion is filtered through the glomerulus and sent on to Bowman’s capsule. The hormonal control of RBF is due to the renin-angiotensin system. Renin is secreted in response to hypotension or hypovolemia to preserve the renal blood pressure by stimulating the cleavage of angiotensin I to angiotensin II. Ultimately, angiotensin II stimulates the release of adlosterone, a potent vasopressor, which increases systemic aterial pressure. Due to the deceased arterial perfusion of the kidney secondary to the stenosis of the celiac artery the body released rennin in response to poor blood flow to the kidney. This caused hypertension in the patient, necessitating the removal of the atrophied kidney and arterial bypass surgery.

ICD-9-CM code 447.4 Other disorders of arteries and arterioles: celiac artery compression syndrome indicates there is celiac artery disease. if you look up stenosis\artery\celiac in the Index, 447.4 is the code listed. Hypertension is secondary to the renal hypotension—not renal disease or cardiac disease, which takes the coder to 405.91 Secondary hypertension; renovascular. It would be inappropriate to code 403.X Hypertensive chronic kidney disease as the “excludes” lists renovascular hypertension, or 405.XX. The acute renal failure is also excluded with 403.X. Since the renal failure and renal atrophy are symptoms of the arterial stenosis and induced hypertension it is not necessary to code them.

CPT® codes are 35631 (53.06 RVU) 50220 -51 (28.26 RVU), and 38102. CPT® code 35631 Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal is for the arterial bypass graft from the supraceliac (above the take off of the celiac artery) portion of the aorta to the superior mesenteric artery (SMA). The dissection of the kidney was poorly documented for the work done to the ureter, since no bladder cuff was noted 50220 Nephrectomy, including partial ureterectomy, any open approach including rib resection; seems the best fit for the nephrectomy. Code 38102 Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure) is reported as a result of an iatrogenic injury that could not be repaired, probably due to the 6,000 units of heparin, a potent anticoagulant. There are a variety of schools of thought as to whether you should report the repair of the iatrogenic injury. It was added here for the sake of example.

Nancy Reading, BS, RN, CPC, CPC-I
Vice President of Education

Have You Gone to Extremes?

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

Operative Procedure: Skull base reconstruction with bone graft, split calvarial, orbital reconstructions with mesh, nasal reconstruction with cantilever bone graft, palatal reconstruction with plated split-thickness calvarial bone graft rectus, myocutaneous free flap. Placement of Alloderm 16 X 4 cm and split-thickness skin graft 7.5 X 10 cm.

Indications: The tumor was misdiagnosed for six months requiring removal by a team of physicians, including a neck extirpative surgeon, a neurosurgeon, and myself. The patient will need additional surgery after planned radiotherapy.

Procedure: A significant defect remained in the skull base when I arrived. The neurosurgeons placed a pericranial flap and the entire inner table of the frontal bone flap. One of the pieces fit perfectly, covering the supraorbital roofs and part of the cribiform area, and was sealed with Hydrocet. The bone flap was placed back on, closing her bicoronal, leaving the facial defect. Mesh plates were fashioned, attached, and cantilevered off the lateral orbital rim to create a new orbital floor, inferior orbital rim, and medial wall of the eye. The eyes appeared symmetrical despite significant swelling. I cut a piece of inner table of calvarium to fashion a cantilever bone graft, which was placed in the glabellar area with a multidimensional plate using 1.7 mm screws. This allows nasal dorsal support and tip protection.

The patient’s palate had a maxillectomy defect. A mandibular plate was fashioned off the zygoma/linear orbital rim providing upper alveolus and nasal spine support and reducing risk of repulsion of her flap, compromising the airway. Remaining split cover grafts were cut into one cm wide strips and placed around the cavity areas with screws. After checking the positioning on the model and sterilizing, the flap was harvested. The plate was placed with bone chips within the fat of the rectus myocutaneous flap.

The rectus abdominis flap was harvested and designed over the right rectus muscle (a PEG tube was placed previously). The proposed skin panel was cut through the fat with a Bovie cautery and outlined in the skin pad of the anterior rectus sheath. We removed the skin and fat to leave only muscle, and the skin graft was placed Intracostal nerves and blood were Ligacliped and divided proximally down to the pedicle. In the right neck, the otolaryngologist had already dissected the facial artery and vein and a tunnel was made between it and the cheek subcutaneously. The pedicle was divided. The abdomen was closed with multiple interrupted braided sutures, and a piece of Alloderm was sutured. Dressing was placed on the abdomen after the skin was stapled. A 19-French Blake was placed and sutured with nylon in the groin.

After removing the upper portion of the skin and fat in the head and neck, we positioned the pedicle for anastomosis with a single suture to the cut edge of the anterior soft palate, laterally to the buccal mucosa and the inner mucosa of the lip. The lip was closed in three layers. Sutures were also used to lateralize the right base of the nasal tip. We found multiple dermal flaps while cutting the artery and a good location with excellent blood flow. The facial and deep inferior epigastric arteries were cleaned and anastomosed using microsurgical techniques. The vena comitans and facial vein were cleaned and anastomosed using a 3-mm couple system. The neck was closed with a single Penrose and sutured.

After the lip reconstruction, the distal muscle was wrapped around the cantilever bone graft and sutured laterally. The subcutaneous incisions were closed using gut, although buried sutures were used to close deeply. Sixteen 7.5 X 10 cm split-thickness “pie-crusted” skin grafts were placed onto the muscle overlying our cantilever bone graft using multiple interrupted fast absorbing gut. The neurosurgeon took the pins out, out; the endotracheal tube was replaced by a number eight Shiley.
Understand Carrier Medical Policy and the Long Denial Process

by Jonnie Massey, AHFI, CPC, CPC-P, CPC-I

When a service is provided to a patient with insurance, it should be paid for, right? That’s what we as patients, providers, or consumers like to believe—if it were only that simple. Generally speaking, when services are provided, one expects compensation. This may not be the case, if the service provided is impacted by medical policy.

Let’s explore medical policy and the process behind developing and reviewing carrier medical policy. Carriers have medical policy that sets coverage guidelines for specific procedures, equipment, and services. To provide for you a better understanding of why service compensation may be denied by carriers, we’ll review the common process used for determining carrier medical policy.

How Medical Policies are Made

Medical policies are determined via an evidence-based review process that may be reviewed in more detail by accessing the individual carrier medical policy development and review process. You can usually review this online or ask for a copy. Please review your carrier’s website or contact them directly for details. Published scientific literature is reviewed against technology evaluation criteria (TEC), all of which must be met for the technology to be considered medically necessary. See the twelve programs the Agency for Healthcare Research and Quality (AHRQ) has designated as evidence-based practice centers.

The TEC are defined as follows:

1. The technology must have final approval from the appropriate government regulatory bodies; and
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes; and
3. The technology must improve the net health outcome; and
4. The technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside investigational settings.

Keep the TEC criteria in mind when submitting data for consideration to a carrier-related to medical policy. Thorough research will be conducted. Embedded in this evidence-based review process is also a rigorous quality review of published studies following nationally recognized standards for assessing scientific literature. Once the evidence is reviewed, policy drafts are submitted for external review by practicing physicians with expertise in the associated technology fields. Examples may include orthopedic surgeons, primary care physicians, and physical medicine specialists as appropriate to the reviewed policy. It is within this context that the submitted evidence is reviewed in its entirety by the medical policy department.

Things to consider when submitting data to a carrier for a medical policy review or research:

- **Clinical trials**: Small-sized clinical trials may not be powerful enough to establish the outcomes’ significance. Considering the prevalence of conditions, are sufficiently powered clinical trials expected?
Randomization: Were methods of randomization described in the articles submitted? Few randomization methods can truly be considered randomized (e.g., computer-generated, coin toss). Without a description of the used method, patient selection bias cannot be ruled out.

Follow-up period: Is the length of follow-up too short? When determining safety and efficacy of a service, longer-term outcomes are considered a measured primary outcome. For example, the short-term benefits such as a reduction in the use of opiates or better initial range of motion often do not significantly impact the length of the recovery period or the success of a surgery in improving symptoms and functional levels for these patients.

Inconsistency: Check for inconsistencies between studies in the measured outcomes and the measurement tools used. This does not permit comparison between most of the available studies.

Mixed results: Have there been mixed results in the reviewed studies? Does the submitted material consist of only articles documenting positive outcomes? Would a literature search reveal other studies not supporting these outcomes?

A search of the MEDLINE database may be conducted in addition to the submitted articles. This search may include reviews of random trials. When providing data to carrier-related medical policy, it is beneficial to include information about random trials specific to your service in the data packet you send for review.

Other areas of review may include: a search of the National Guidelines Clearinghouse database and research of the clinical practice guidelines and position statements.

If you feel it’s necessary to send patient or physician letters to support your position, know that letters may be considered anecdotal evidence not meeting the national standards for scientific literature. The benefits reported in anecdotal evidence often are not seen when tested in randomized clinical trials. Patient surveys such as requests for personal experience reports included within submitted patient letters tend to be answered by the patients who have positive experiences. This evidence cannot be considered unbiased. The submitted anecdotal evidence will not be included in the critical appraisal of the published literature.

If there isn’t new data in the published literature, the current medical policy usually remains in place. Medical policy staff continue to monitor the peer-reviewed, published literature on a regular basis. If the literature changes and the five technology assessment criteria are met, the medical policy will be updated.

What Medical Policy Doesn’t Do

Medical policy does not determine the schedule of benefits, but rather, it dictates the process that determines if the services will be paid by the carrier. Keep in mind, medical policy application is subject to state and federal laws, and specific instructions from plan sponsors and self-insured groups.

Medical policy is not medical advice. Questions and concerns about treatment should always be directed to the health care provider. Should a provider or patient use a service or device not allowed by carrier Medical Policy, a waiver clearing indicating the service must be signed prior by the patient before receiving the service.

If you are unclear on the medical policy or you have concerns about a service you provide and how the policy applies, contact your carrier and explore available options. As always, check with your carriers prior to providing a service or device that may be addressed by medical policy.
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A new federal auditing program is coming to city near you.

The Recovery Audit Contractor (RAC) program, created in 2004 through the Medicare Modernization Act (MMA) to safeguard the Medicare Trust Fund, identifies Medicare and Medicaid overpayments and requests repayments from facilities, physician practices, and DME providers. A demonstration project begun three years ago in Ariz., Calif., Fla., Mass., N.Y., and S.C. recovered $357.2 million in overpayments for the six states in the federal government’s 2007 fiscal year.

CMS is delighted with the success of its pilot program, which identified and collected overpayments not previously caught by Medicare Affiliated Contractors (MACs). The cost to the government is 22 cents for each dollar returned to the Medicare program, a worthwhile payoff by anyone’s standard. The hope is that by recovering these costs, short-term gains will be followed by long-term cost savings for Medicare providers and members alike. “We need to ensure accurate payments for services to Medicare beneficiaries and by taking this important step, people with Medicare can be assured they are being charged correctly for their share of their health care services,” acting CMS administrator Kerry Weems said recently.

CMS announced in March that the RAC program will be operational in 2009 and will name four regional RACs this spring. The RACs will be private companies equipped with proprietary Medicare edit systems, and they will earn a percentage of collected refunds. The only states exempt from participation will be those undergoing a Medicare Administrative Contractor (MAC) transition, and they will be exempt only during the transition period.

RAC isn’t the same as Medicare’s Comprehensive Error Rate Testing (CERT) program that was implemented in 2003. In CERT, Medicare contractors’ work is evaluated for their ability to detect errors. CERT evaluates program performance while RAC evaluates individual provider compliance. CERT continues to operate as a parallel program as RAC ramps up.

How Does RAC Work?

In the RAC program, it’s all about the money. Auditors aren’t looking for perpetrators of fraud; they’re reviewing claims to uncover errors in code selection or medical necessity requirements. Contractors working in the RAC program run Medicare claims through proprietary editors that identify practices where coding and billing errors occur or practices with high frequencies of procedures targeted by the Office of Inspector General (OIG). In either case, the targeted practices are required to respond to RAC requests for patient records and other information.

For facilities, the RACs review medical records for which diagnosis-related groups (DRGs) were reported. For providers, the RACs inspect medical records filed under Part B. For most Medicare Part A and B situations, the RAC sends a request to the provider for a photocopy of the entire medical record for the encounter and payment in question.

A recipient of the letter shouldn’t redact the requested records, as RACs are authorized by CMS to view this information. A response to the RAC request must be delivered within 45 days. The RAC has 60 days to review the record and notify the provider of the outcome of the review. A request may ask for one specific record or multiple records. It’s critical that the record is photocopied in its entirety for the RAC, as incomplete records could result in additional findings of insufficient documentation.

In some cases, the contractor’s data mining systems determine claims that clearly don’t meet the requirements of Medicare policies and don’t require medical records because it is so obvious an overpayment occurred. CMS reviews a percentage of these determinations before the letters are sent.

Good Coding is the Best Prevention

CMS says bad coding is the biggest cause of the problem, even though the error rate determined through CERT has dropped from 14.2 percent in 1996 to 3.9 percent in 2007.

During the pilot program, almost half of repayments resulted from incorrect coding. According to a press release from CMS, the types of inadvertent
errors leading to improper payments found by the RACs include the following examples:

- A health care provider billed Medicare for conducting three colonoscopies on the same patient on the same day;
- Payments were made for services that were coded incorrectly—for example, Medicare was billed for a certain procedure but the medical record shows that a different procedure was actually provided;
- A health care provider was paid twice because the provider submitted duplicate claims;
- A claim was paid using an outdated fee schedule.

In these examples, the RAC would issue a repayment request for the amount paid for the extra service or the incorrect coding. If the beneficiary paid wrong copayment amounts, the health care provider would need to reimburse the patient for those copayments.

**How Can You Prepare?**

What can you do to prepare before you receive a letter from your RAC?

**Assess the situation.** Perform your own retrospective audit, going back as much as three years to see what you uncover. Don’t focus on E/M leveling, as this is a topic that has temporarily been excluded from RACs as CMS considers an AMA proposal to change the way these services are reviewed. However, the auditors will still look at duplicate billings, global rules, and procedures on the same day as an E/M, new vs. established patients, and consultation issues.

**Educate your team about RAC.** Who opens the mail at your practice or facility? If a letter from RAC isn’t immediately identified, precious time could be wasted, hobbling your response. The mail room, front office, back office, finance team, receptionist, or unlucky intern should all be aware of the RAC program and alert to any RAC correspondence.

**Employ certified coders.** CMS is requiring RACs to use certified professional coders in their reviews. If you aren’t using certified coders, consider hiring some, or certifying those you have. Certified coders can talk peer-to-peer, which is an advantage to use during an audit. The other plus is the knowledge and professionalism certified coders will bring to your office.

**Pick a single RAC point person.** Your office should have one person charged with managing any RAC queries when they come. This person will document all correspondence, perform concurrent review of records that are sent to RAC, and keep management apprised.

**Keep one for each of you.** Be sure to keep a copy of every page you turn over to the RAC; and, while you can’t amend or change the records, you can submit an addendum explaining why something was billed a particular way.

**Study the 2008 OIG Work Plan.** Many of the targets for RACs are taken directly from the OIG Work Plan, which can be downloaded at www.oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf. Some of the issues in the 2008 work plan include the following:

- *Incident to* services provided by non-physician practitioners. Medicare has very specific rules regarding reporting services provided by physician assistants (PA) or nurse practitioners (NP). A PA or NP can be paid at 100 percent of the physician rate if the physician establishes a treatment plan for the patient and is in the office at the time of the encounter. Otherwise, the PA or NP is reimbursed for services at 85 percent of the rate paid to a physician. Not adhering to these rules can be very expensive if your practice is audited and you are found noncompliant.

- **Check place of service codes.** If you perform surgery in an ambulatory surgical center (ASC) or outpatient hospital, ensure that you are reporting the correct place of service code for these surgeries. If you report these surgeries with the code for your own office rather than an ASC or outpatient hospital, you will be overpaid for the services.

- **Observe global periods.** Ensure you aren’t billing for follow-up office visits occurring within the global period of the surgery. These visits are considered part of the surgical package and shouldn’t be separately reported.

- **Watch unbundling of procedures.** Keep current with the National Correct Coding Initiative (NCCI) to ensure your office isn’t billing for more procedures...
than is appropriate. For example, if during a diagnostic colonoscopy the physician removes some polyps by snare, the code for the colonoscopy with snare retrieval of polyps is the only code reported. The diagnostic colonoscopy is bundled into the primary procedure.

**Assure Medical necessity.** Ensure that the services provided to the patient meet the medical necessity requirements found in the National Coverage Determinations (NCDs) accessed on the Medicare website and Local Coverage Determinations (LCDs) approved by the MACs. Ensure the diagnosis is adequately documented in your medical record for the patient. “Rule out” diagnoses are never acceptable diagnoses and be sure coders can find a “real” diagnosis in the record. For example, “rule out pneumonia” may be a reason for a chest X-ray, but the chart should describe why pneumonia was suspected. Fever, cough, and chest pain all can be coded and all meet the medical necessity rules for the chest x-ray; “rule out pneumonia” cannot and does not.

**Confirm units of service.** From x-ray services to pharmaceutical injections, ensure that the correct unit number is reported in the claim. One of the common errors cited in the RAC report involved billing for pegfilgrastim. In the past, one unit of the HCPCS Level II code for pegfilgrastim was reported for each milligram of drug delivered, but CMS changed the fee schedule and rules several years ago, and providers were told to bill one unit of the HCPCS Level II code for each vial of drug delivered. Because the cost of one vial of pegfilgrastim costs more than $2,000, recovery from misreporting of administration of this drug was significant.

**Know Medicare rules.** RAC contractors will be monitored by CMS, but it’s always possible that a contractor will misinterpret the local and national coverage decisions regulating how you bill for a particular service. You can help the RAC contractors—and yourself—by clarifying particular situations. Knowledge is power.

**When Will You See It?**
If you’re not in one of the demonstration states, you have time to prepare. While CMS admits the dates are flexible and that some states may not see RACs if they’re undergoing a MAC transition, they expect the following states to begin RAC this spring. In addition to the demonstration states (save for Calif.): Ariz., Mont., Wyo., N.D., S.D., Minn., Colo., N.M., Ind., Mich., N.H., R.I., and Maine. States looking at fall implementation include Calif., Hawaii, Nev., Okla., and Texas. The rest will see RAC in 2009 at the very latest.

For more information on the RAC program and to view the FY 2007 Status Document, visit: http://www.cms.hhs.gov/RAC

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Coding Edge Tests Your Knowledge

June 2008

1. What federal program plays heavily into the Medicare physician fee schedule this year?
   a. CERT
   b. RAC
   c. PQRI
   d. OPPS

2. What code is used when several patients are being treated in a PT clinic and have a common, unifying element?
   a. 97010
   b. 97011
   c. 97150
   d. 97113

3. An ABN is given to a Medicare beneficiary for what purpose?
   a. When the copay is waived
   b. When the test results are all but normal
   c. When the service is likely not to be covered
   d. When the practice is being audited by OIG

4. For 2009, CMS has proposed what for ICD-9-CM?
   a. Fewest changes in a decade
   b. Removal of the V codes
   c. Most changes in a decade
   d. Addition of section for alternative therapies

5. Payer medical policy is determined via what?
   a. High level meetings of insurance executives, physicians, and lawyers
   b. Application to state insurance commissions
   c. Evidence-based review process
   d. Annual meetings of payer actuaries

6. Use what modifier to report a waiver of liability or ABN on file?
   a. 59
   b. CC
   c. GA
   d. 52

7. When a RAC requests records, you should do what?
   a. Provide redacted claims only to avoid HIPAA violations
   b. Provide only summaries of each record
   c. Make complete copies of each record for the RAC and you
   d. Amend the records to correct any mistakes

8. Which federal program is similar to, but not the same as the RAC?
   a. MPFS
   b. ABN
   c. CERT
   d. PQRI

9. You have how many months to implement the new ABN forms?
   a. Three months from March 3
   b. One year from July 1
   c. Six months from March 3
   d. Six months from July 1

10. ICD-9-CM may have a dozen codes dealing with what current issue?
    a. Teen drinking
    b. Closed head injuries
    c. Pap smears and HPV
    d. Post traumatic stress disorder
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