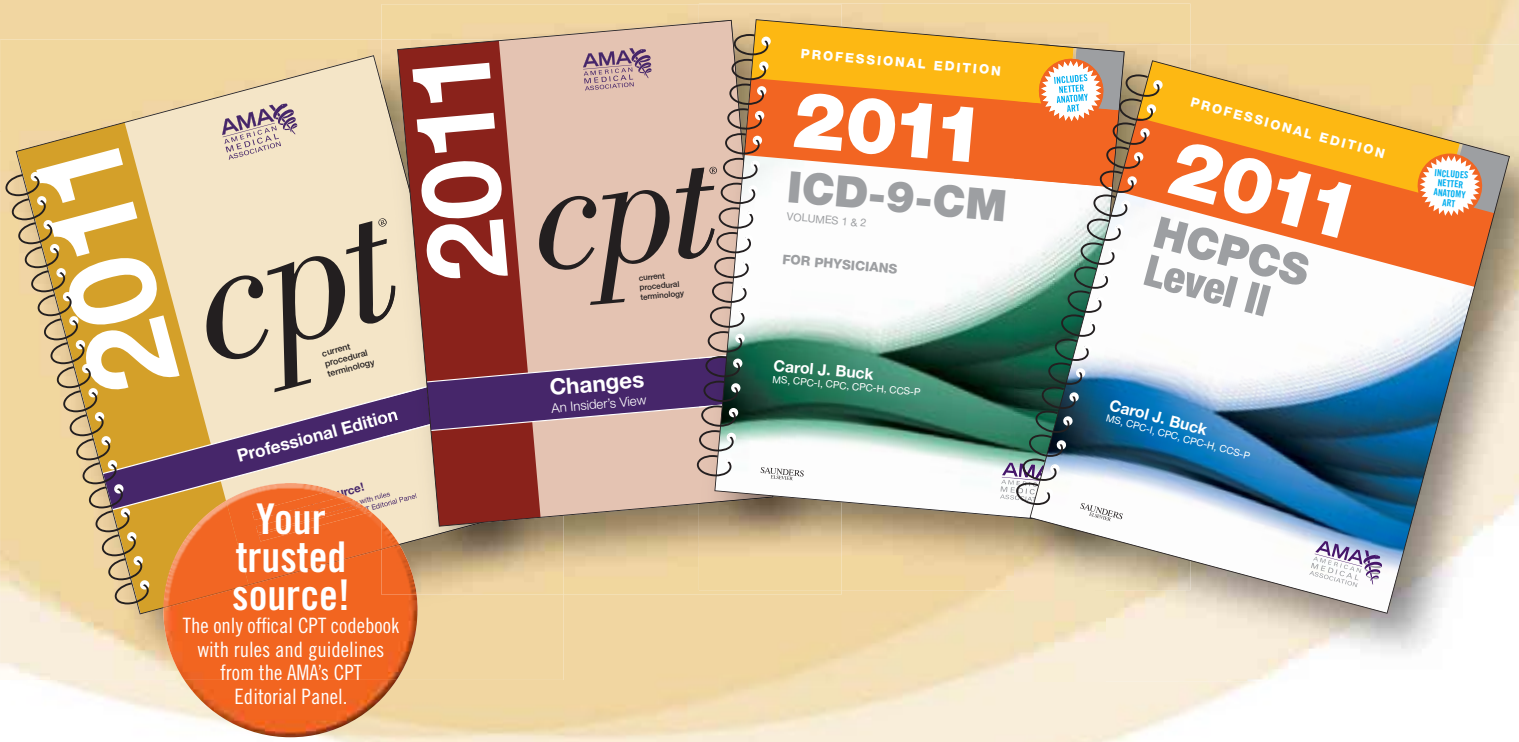
American Academy of Professional Coders
CODING edge
April 2010

Lives Enhanced by Coding

Jacqueline J. Stack,
AAB, CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC, CCP-P
Oil City, Pa.

Plus: Vaccines • CR ICR PR • Radiation Therapy • 2010 PQRI • Neoplasms • Preventive Medicine

Professional products developed with today's medical coder in mind

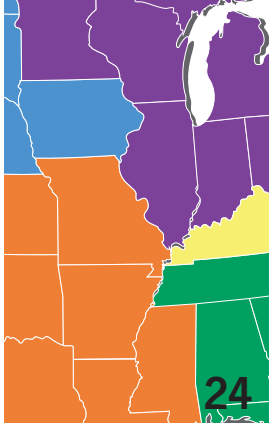


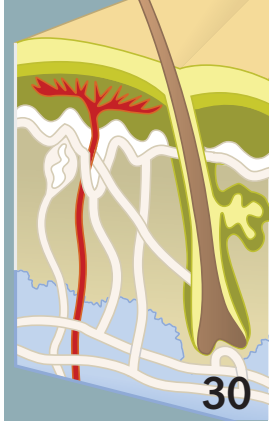
Optimize reimbursement and improve efficiency with the AMA's NEW 2011 codebooks.

Go to ***www.amabookstore.com*** today and view special package deals on these titles and more!

AMA
AMERICAN MEDICAL ASSOCIATION

American Academy of Professional Coders
CODING edge
April 2010





[contents]

Features

On the Cover: *When Jacqueline J. Stack, AAB, CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC, CCP-P, of Oil City, Pa. reflects on her coding journey, she sees her credentials as the key to achieving new heights. Cover photo by Dave Cyphert (www.propointmedia.com).*

In Every Issue

Education

People

Coming Up

Mentoring

Modifiers 50, LT, RT

2009 Coder/Networker

Coding from Notes

SNF

Serving 88,000 Members – Including You

Serving AAPC Members

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

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

advertising index

American Academy of Professional Coders
CODING edge
April 2010

Address all inquires, contributions and change of address notices to:
Coding Edge
PO Box 704004
Salt Lake City, UT 84170
(800) 626-CODE (2633)

Volume 21 Number 04 April 1, 2010

Coding Edge (ISSN: 1941-5036) is published monthly by the American Academy of Professional Coders, 2480 South 3850 West, Suite B. Salt Lake City, Utah, 84120, for its paid members. Periodical postage paid at the Salt Lake City mailing office and others. POSTMASTER: Send address changes to:
Coding Edge c/o AAPC, 2480 South 3850 West, Suite B, Salt Lake City, UT, 84120.

A Life Enhanced Through Coding

Our cover feature in this month's *Coding Edge* talks about individuals whose lives have been changed by a career in medical coding. In that spirit, I'd like to relate my own "coding journey."

A year out of school, I still wasn't sure what I wanted to be when I grew up. I had always enjoyed writing, however, so when I saw a "help wanted" ad in my local paper seeking an editorial assistant for a newsletter publishing company, I jumped at the chance. After six weeks and three interviews, I landed an entry-level job with the publishers of *Coding Alert* newsletters.

During this time, I had to absorb a lot, rapidly. Not only did I have to learn about publishing and hone my editing skills, I had to master the daunting concepts and language of medical coding. With the help and encouragement of my supervisors, coworkers, and especially those coding experts who were willing to share their own expertise with me, I was able to advance quickly. I began writing for the *Coding Alert* newsletters and tapping into my love of teaching by occasionally speaking on coding topics. As a coding educator, I had the responsibility to master my subject. I think I did that when, in January 2003, I become a certified professional coder (CPC®).

A year and a half ago, I joined the AAPC as Director of Clinical Coding Content. I review and edit the articles in *Coding Edge* and other AAPC publications for coding accuracy, and write and teach on coding topics. It's not always easy to explain "what I do" at a party, but I'm grateful to have found a profession that keeps me engaged and that challenges me to keep learning and improving my skills.

My story may not seem typical, but it points out that a successful career in coding may follow a variety of paths. Many AAPC members aren't strictly coding claims in the office or facility. They may be coding educators, compliance experts, or auditors. Evolving conditions bring new opportunity.

You have to reach for the opportunities available to you, even if it means going outside your comfort zone.

Consider the potential rise of electronic medical records (EMRs). Like any tool, the EMR must be designed, applied, and maintained properly. It will need to be customized and updated to meet the needs of the particular setting in which it is applied. EMR use will have to be monitored to ensure that compliance and coding rules are followed. Who better than coders—working hand-in-hand with providers—possess the knowledge to meet these challenges? Whatever your feelings on government-sponsored health care; rising medical costs inevitably will bring ever-closer scrutiny from government and private payers. The coder's role becomes more central in such an environment.

I believe my story is typical in demonstrating that several factors contribute to a successful coding career. First, you have to reach for the opportunities available to you, even if it means going outside your comfort zone. As Will Rogers said, "Even if you're on the right track, you'll get run over if you just sit there." Next, it's important to stay current and keep yourself educated. Lastly, be involved. Coders are their own best resource, so be sure to share your questions and your knowledge. You'd be surprised what you can learn by teaching. Go to your local AAPC chapter meetings. Join the AAPC message boards. Consider submitting an article to *Coding Edge*. Become a mentor: I never would have succeeded without the help of my mentors—many of whom I call on still.

Involve yourself, and you'll not only improve your skills as a coder, but like me, you'll likely gain some great friends in the process.

Sincerely,

G. John Verhovshek, MA, CPC

The American Society of Health Informatics Managers™, Inc is a professional member association for IT professionals who specialize in Health IT (HIT). ASHIM™ is a non-profit, non-governmental organization that conducts a nationally recognized credentialing exam to certify the healthcare industry knowledge of working level IT professionals, known as the Certified Health Informatics Systems Professional (CHISP™).

ASHIM™ members believe in the importance of a skilled Health IT workforce to best serve the needs of physicians who are using and adopting health IT.

CHISP™ certified IT professionals provide physicians with the best of both worlds.

ASHIM™
American Society of Health Informatics Managers

ashim.org

Keep Billing In-house or Contract it: You Decide

As the president and CEO of a billing company, I have seen firsthand the pros and cons for using a billing company. Whether you are contemplating changing billing companies or establishing in-house billing, you should know neither is a perfect situation. If you like to be in control and feel you can hold down costs, maybe in-house billing is right for you. If you're a large group, however, utilizing a billing company can reduce your overhead and a tremendous amount of responsibility.

Today's Technology Requires Greater Investment

While traveling for billing and coding consulting, I find many physicians who still believe anyone can put a bill out. That may have been true 10-15 years ago, but not today. The health care industry continues to go through massive changes such as Health Insurance Portability and Accountability Act (HIPAA), ICD-10, recovery audit contractor (RAC) audits, the 5010 transaction standard, government controlled health care, clearing houses, electronic funds transfers (EFT), and billing system costs that can easily reach six digits.

To help you decide on whether in-house billing or hiring a billing company is right for your practice, consider this:

When a billing company guarantees to increase revenue, run the other way. The only thing they should guarantee is compliance. If your documentation and claims are compliant, then you'll collect maximum revenue. To guarantee increased revenue is a red flag for fraud.

All coding should be performed or supervised by a certified coder. Coding rules change annually. The responsibility of utilizing correct tools of the trade, reporting documentation deficiencies, and asking the physician documentation questions falls on the coder. Coders are an integral part of the team, the same as billers, nurses, technologists, and even physicians. They understand the coding rules and help a practice with compliance if audited.

Check the days in accounts receivable (A/R). Someone in the group should look over the monthly reports. Many managing partners do not understand their reports, which makes running them a waste of time. You should carefully review the age of monthly claims. The majority of claims should be in either the 30 or 60 day aging buckets. These two buckets generally are considered "current charges," based on the premise that all clean claims will be paid within 60 days or less. If you find large amounts of claims sitting in the 90, 120, 150, or 180 buckets, there is a problem with your system, billing, coding, staff, documentation, and/or payer. You should have 10 percent or less in these buckets, especially the 120 day or older buckets. If you have a lot of old claims that aren't paid, contact the carrier and ask why.

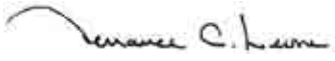
If you are billing in-house, is your system sophisticated enough for billing staff to complete follow-up tasks, correct insurance correspondence, post payment, and call carriers? Are the majority of your claims posted electronically? Do you send out claims daily? Do you have adequate staff and do you invest in their continued training? With major changes coming at us over the next 3-4 years, it will not be business as usual.

What is your plan for converting to ICD-10? Your system should accommodate billing the old accounts receivables with ICD-9 simultaneously with new claims using ICD-10. Physicians should be trained in the documentation requirements. Your billing company should assist the physicians with some of that training.

Billing and coding staff should have regular meetings to perform claim audits. Billers should alert coders of any denials based on coding errors. Fixing claim denials based on coding errors is a coder's responsibility, not the billing staff. Whenever I mention this to coders, I am told they have never met the billing staff. How can a coder know what a carrier requires, and a biller fix the coding errors confidently, without communication?

Only you can decide what is best for your group or office. Consider hardware, software, staff education, staff training, and upcoming changes before making a choice; the wrong decision may be more costly than you can afford.

Sincerely,



Terrance C. Leone, CPC, CPC-P, CPC-I, CIRCC
President, National Advisory Board

coding news

Implementation Date Set for April OPPS Changes

The Centers for Medicare & Medicaid Services' (CMS) April 2010 update of the hospital Outpatient Prospective Payment System (OPPS) implementation date is April 5. The Recurring Update Notification, Change Request (CR) 6857, describes changes to and billing instructions for payment policies implemented in the April 2010 OPPS update.

This CR affects chapter 4, sections 200.9 and 240.1 and chapter 32, section 140.4.1 of the *Medicare Claims Processing Manual*. Updates include:

- April 2010 Integrated Outpatient Code Editor (I/OCE); and
- OPPS Pricer reflecting the HCPCS Level II, Ambulatory Payment Classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions.

The most notable change is in chapter 32, "Billing Requirements for Special Services, 140.4.1—Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010," which states:

If medically necessary, separately reportable respiratory or pulmonary services are furnished to a patient in a hospital or practitioner's office and those services do not meet the diagnosis and coverage criteria for pulmonary rehabilitation services, then those services should not be reported using HCPCS code G0424 but should be reported using the appropriate CPT® or HCPCS codes.

Other significant changes are to 240.1—Editing of Hospital Part B Inpatient Services, which previously applied only to fiscal intermediaries (FI), but now includes specific instructions for Part A and Part B Medicare Administrative Contractors (A/B MACs), as well.

Codes 038X and 039X have been added to the list of Revenue codes for the contractor to use to prevent payment on Type of Bill (TOB) 12x claims.

For the complete CMS CR, go to www.cms.hhs.gov/transmittals/downloads/R1924CP.pdf.

VMS Tests for HIPAA 5010

The ViPs Medicare System (VMS) shared system maintainer will test end-to-end Health Insurance Portability and Accountability Act (HIPAA) 5010 changes and interfaces to assure all changes are made correctly. Implementation date is July 6.

This policy is part of the Health Insurance Reform modifications to HIPAA final rules published in the *Federal Register* on Jan. 16, 2009 by the U.S. Department of Health and Human Services (HHS), 45 CFR Part 162.

According to CMS, the VMS shared system maintainer should:

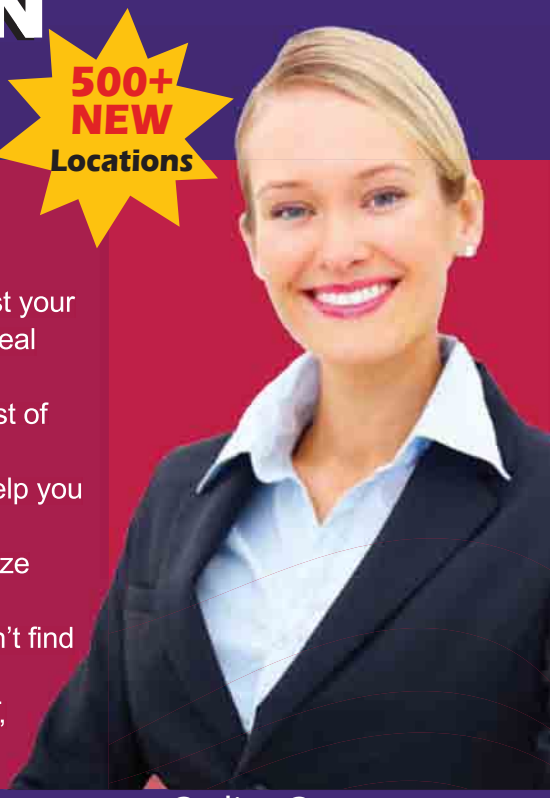
- *Execute HIPAA 5010 and D.0 End-to-End testing on the VMS system to verify implementation. Where feasible this testing will also include exchanging test files with CERT and COBC, as well as CEDI to verify external interfaces. This testing should include simulation testing of the cut-over, using 4010A1 and NCPDP 5.1 transactions and then moving to only 5010 and NCPDP D.0 transactions, to ensure a smooth transition.*
- *Rectify errors found during the HIPAA 5010 testing. If not feasible for any reason, maintainer will log errors, and schedule them to be fixed under a subsequent Change Request.*

In accordance with HIPAA standards, Version 5010 will allow for reporting the extra digits required for ICD-10-CM code system implementation, which is scheduled for Oct. 13, 2013.

For more on Version 5010, see "Version 5010: More Than a Software Update" on page 44 of this issue of *Coding Edge* and CMS transmittal 6460, available for download at: www.cms.hhs.gov/transmittals/downloads/R646OTN.pdf.

CODING CERTIFICATION TRAINING CAMP

500+ NEW Locations



Now, preparing for the AAPC's CPC® Exam is just a driving distance away. Our AAPC approved instructors are coming to YOUR hometown ready to provide you with exam-taking tips and preparation you won't find anywhere else. Best of all, 3 days are all it takes to prepare for the exam! How? With CodingCert.com's **3-Day CPC® Training Camps!**

CPC® TRAINING CAMP COURSE OVERVIEW:

- Exam-taking tips guaranteed to boost your confidence and prepare you for the real thing!
- Tricks of the trade that make the most of the open-book format
- Time management tactics that will help you get through the full exam
- Intimate classroom setting to maximize interaction with your trainer
- Checklists and study guides you won't find anywhere else
- Advice for tackling ALL areas of CPT, and much more!

CodingCert.com
Get Certified. Get Ahead!

For additional information please contact CodingCert.com at (866) 458-2962 and mention code VCPCE410 or visit us online at www.CodingCert.com

Become a Certified Specialty Coder and earn 28% more!

Distinguish yourself! Become a Certified Specialty Coder and take your career to new heights. You've already taken all the necessary steps to become a medical coder, so why stop now? Expand your coding knowledge, boost your career opportunities, and demonstrate your abilities to overcome your specialty's coding, billing and reimbursement challenges!

Best of all! *CodingCert.com* can prepare you for the AAPC's Specialty Credential exam in just 3 days. How? With our **3-day Specialty Credential Training Camps.**

Prepared by leading coding and billing experts, and **scheduled all over the nation**, including AZ, CA, CO, FL, GA, IL, NJ, OH, TX, and many more, these training camps will provide you with all the necessary tools and education to help you successfully pass your AAPC's Specialty Credential exam.
You have 5 Specialty Credential Training Camps to choose from:

> Certified **Anesthesia and Pain Management** Coder (CANPC™) Training Camp
> Certified **Cardiology** Coder (CCC™) Training Camp
> Certified **Evaluation and Management** Coder (CEMC™) Training Camp
> Certified **Obstetrics Gynecology** (COBGC™) Training Camp
> Certified **Orthopaedic Surgery** Coder (COSC™) Training Camp

Note: You are no longer required to be a CPC® to obtain your specialty credentials.

CodingCert.com
Get Certified. Get Ahead!

For additional information please contact CodingCert.com at (866) 458-2962 and mention code VCPCE410 or visit us online at www.CodingCert.com

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

Letters to the Editor

Subsequent Care Codes Are Appropriate for Inpatient Consultative Services, CMS Says

In response to Karen Pettit's article discussing Medicare requirements to report consultation services ("CMS Provides Reporting Consultative Services Details," March 2010 *Coding Edge*, pages 34-37): *MLN Matters* SE1010 does give specific instruction on appropriate coding to Medicare payers for inpatient consultative services that do not meet the documentation requirements to satisfy level of service 99221 *Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity.*

The Question and Answer portion of MLN SE1010 offers the following information:

Q. How should providers bill for services that could be described by CPT® inpatient consultation codes 99251 or 99252, the lowest two of five levels of the inpatient consultation CPT® codes, when the minimum key component work and/or medical necessity requirements for the initial hospital care codes 99221 through 99223 are not met?

A. There is not an exact match of the code descriptors of the low level inpatient consultation CPT® codes to those of the initial hospital care CPT® codes. For example, one element of inpatient consultation codes 99251 and 99252, respectively, requires "a problem focused history" and "an expanded problem focused history." In contrast, initial hospital care code 99221 requires "a detailed or comprehensive history."

Providers should consider the following two points in reporting these services. First, CMS reminds providers that code 99221 may be reported for an E/M service if the requirements for billing that code, which are greater than consultation codes 99251 and 99252, are met by the service furnished to the patient. Second, CMS notes that subsequent hospital care codes 99231 and 99232, respectively, require "a problem focused interval history" and "an expanded problem focused interval history" and could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by consultation code 99251 or 99252.

Q. How will Medicare contractors handle claims for subsequent hospital care CPT® codes that report the provider's first E/M service furnished to a patient during the hospital stay?

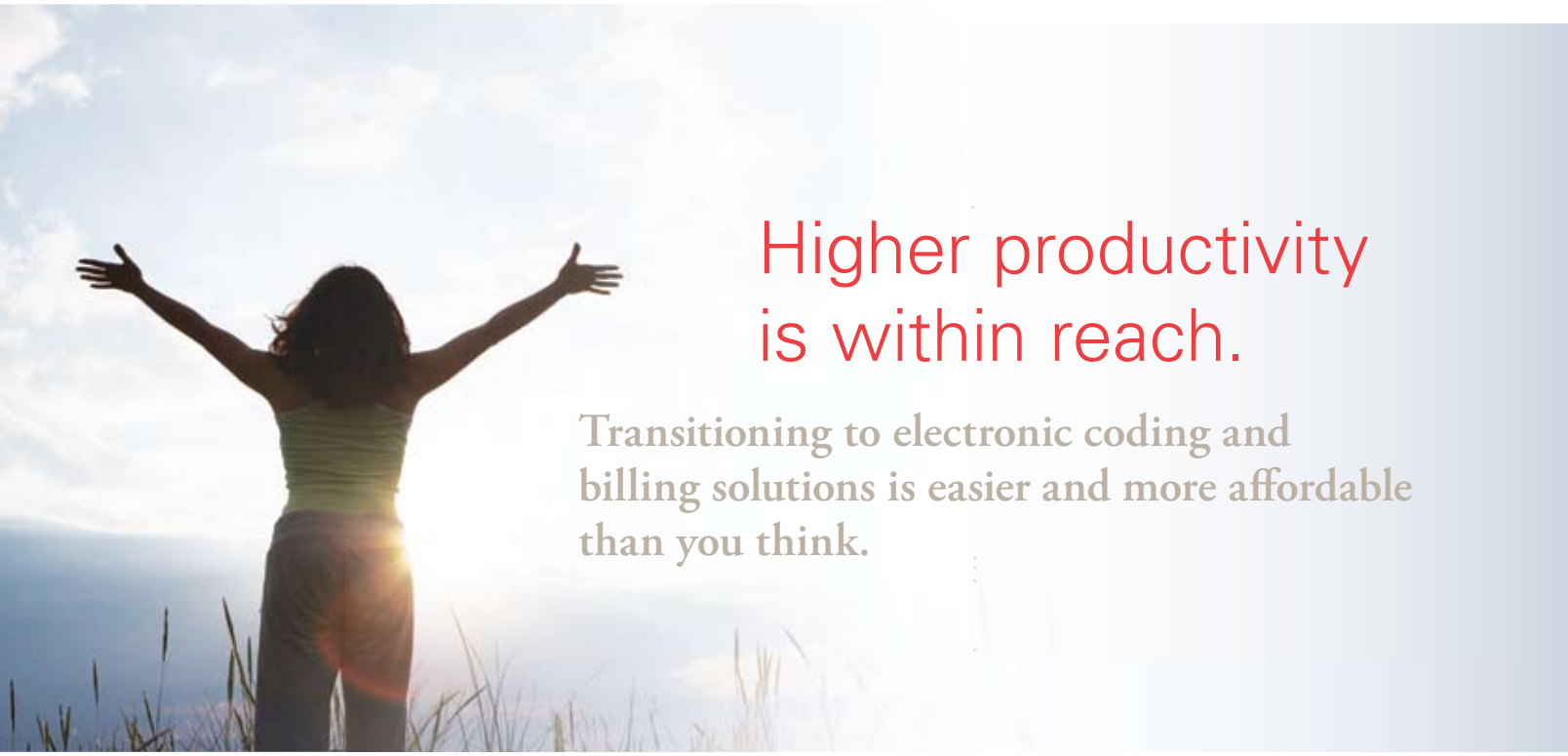
A. While CMS expects the CPT® code reported accurately reflects the service provided, CMS has instructed Medicare contractors to not find fault with providers who report a subsequent hospital care code in cases where the medical record appropriately demonstrates that work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

From these statements, it's clear that, as a matter of national policy, the Centers for Medicare & Medicaid Services (CMS) supports the use of subsequent hospital care codes 99231-99232 *Subsequent hospital care, per day, for the evaluation and management of a patient* to report inpatient consultative services that do not rise to the level of an initial inpatient service, 99221.

For instance, an endocrinologist is called to consult one of his patients who is admitted to the hospital for a hip fracture. The orthopedist billed the admit 99222-AI *Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.- Dressing for one wound*. Because the endocrinologist knows this patient—and because this patient was recently seen by him or her (three weeks ago)—the documented history is only an expanded problem-focused history. Because initial hospital visits need three out of three elements, the visit that included this expanded problem-focused history, expanded problem-focused exam, and moderate medical decision making does not meet the documentation guidelines for a 99221-99223. It does meet the medical necessity and documentation guidelines for a 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity*, so for Medicare, it should be coded as a level two follow-up visit in place of a consultation.

Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC
President, CRN Healthcare Solutions

Thanks for the update! Readers can find *MLN Matters* article SE1010 on the CMS website, at www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf.



Higher productivity is within reach.

Transitioning to electronic coding and billing solutions is easier and more affordable than you think.

The industry is switching to electronic coding and billing solutions. Aside from the fact that this switch is inevitable, change is good. Electronic processes help you:

- Save time and money
- Increase accuracy which reduces denials and helps you get complete reimbursement
- Require less storage space and paper
- Simplify the transition to ICD-10, so you'll remain compliant

You may think that converting to *e*solutions is a complex and expensive undertaking. But we make it fast, easy, and affordable with customized training, online support, and code book and eSolution packages that help you ease into the transition.

The future of coding is now. What are you waiting for?

> "Ingenix EncoderPro Expert has cut down on the number of rejections, reduced re-work, and decreased the average number of AR days. It has also improved our productivity, and so we get reimbursed properly for the services we provide."
>
> **—Mary Beth DeGray,**
> Indian Stream Health Center
> Revenue Cycle Manager

MAKE THE SWITCH

Our *e*solutions Specialists can help you choose the products to fit your needs and budget.

Call (800) INGENIX (464-3649), option 1, or visit www.shopingenix.com/transitionAAPC.

INGENIX®

Identify and Target

Correct Neuro Radiosurgery Codes

Blast away coding misconceptions for proper neurosurgeon payment.

By Janice G. Jacobs, CPA, CPC, CCS, ROCC

Stereotactic radiosurgery is a noninvasive method of delivering external radiation to eradicate or immobilize tumors or other abnormalities using highly-focused gamma rays or X-ray beams that converge on the area of interest with minimal damage to the surrounding tissues.

Stereotactic radiosurgery is performed on various types of equipment that use different instruments and sources of radiation. These include the Gamma Knife®, linear accelerator (LINAC, which includes CyberKnife®), or proton beam (heavy-charged particle) radiosurgery. The Gamma Knife is best suited for small or medium lesions, whereas a linear accelerator is preferable for larger tumors treated in a single session, or with multiple sessions or fractionation. Proton beam therapy is not used widely in the United States; however, the number of radiation therapy centers offering this service has increased in recent years.

The coordination of care for a patient diagnosed with a lesion of the nervous system requires a team of professionals including: the neurosurgeon and the radiation oncologist, as well as the physicist, dosimetrist, and radiation therapist/technician. The radiation oncologist and neurosurgeon oversee the treatment and monitor results.

Clarify Spotty Coding

Coding and billing for these services can be complex and confusing due to the nature and extent of the treatments. For example, the radiation treatment management may be billed by both physicians overseeing a course of treatment; however, each physician has his or her own distinct set of codes in two separate sections of the CPT® manual Surgery/Nervous System (Neurosurgeon) and Radiology/Radiation Oncology (Radiation Oncologist).

The cranial stereotactic radiosurgery codes (61795-61800) are listed in the Surgery/Nervous System section of the CPT® manual, and cover services performed by the neurosurgeon. The radiation oncology codes (77261-77790) are listed in the Radiation Oncology section of the CPT® manual, and cover services such as treatment planning, physics, dosimetry, devices, treatment delivery, treatment management, and other special services.

Until the introduction of CPT® 2009, neurosurgeons had only a single code, 61793, available to cover all stereotactic radiosurgery services. Beginning in January 2009, 61793 was deleted because it no longer described adequately services the neurosurgeon performed. In its place, seven new codes were added to identify and capture better these services:

61796 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion

+61797 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (list separately in addition to code for primary procedure)

61798 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion

+61799 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (list separately in addition to code for primary procedure)

+61800 Application of stereotactic headframe for stereotactic radiosurgery (list separately in addition to code for primary procedure)

63620 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion

+63621 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (list separately in addition to code for primary procedure)

Note: The codes are divided into two broad categories: those pertaining to cranial lesions and those pertaining to spinal lesions.

Cranial Lesions: Simple and Complex

Use CPT® 61796 and add-on 61797 for simple cranial lesions of less than 3.5 cm at their maximum dimension that do not otherwise meet the criteria for complex lesions (as outlined below).

Use code 61798 and add-on code 61799 for complex cranial lesions. All lesions that are 3.5 cm or greater at their maximum dimension are considered complex. "Any lesion

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

Beginning in January 2009, 61793 was deleted because it no longer described adequately services the neurosurgeon performed. In its place, seven new codes were added to identify and capture better these services.

[regardless of size] that is adjacent (within 5mm) of the optic nerve, optic chasm, optic tract, or within the brainstem is complex," according to CPT® instruction.

For example, a patient presents with two astrocytomas of the frontal lobe, one 2 cm and the other 1.5 cm. Correct coding in this case is 61796, 61797.

In a second example, a patient presenting with a 4.0 cm glioblastoma of the temporal lobe is coded as 61798.

When coding for treatment of multiple lesions, if one of the lesions is complex, report 61798 with 61799 for each additional lesion. Do not use 61796 at the same time as 61798.

For example, a patient presents with two gliomas within the brain stem, one 2.5 cm and the other 1.0 cm. Correct coding is 61798, 61799.

When performing a procedure that creates a therapeutic lesion, such as a thalamotomy or pallidotomy, report a single unit of CPT® code 61798 regardless of the number of therapeutic lesions created.

For example, a patient presents with Parkinson's Disease and the neurosurgeon performs a therapeutic pallidotomy. During the procedure a small part of the globus pallidus is destroyed. This creates a scar that relieves symptoms, such as tremors and rigidity, and improves balance. Correct coding is 61798.

Note: Because computer-assisted planning is included in 61796-61799; add-on code 61795 *Stereotactic computer-assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal* is not used with those codes.

As illustrated in the above examples, primary stereotactic radiosurgery codes 61796 and 61798 are reported only once per course of treatment. Also, add-on codes 61797 (simple) and 61799 (complex) are not reported more than four times in any combination for the entire course of treatment, regardless of how many lesions are being treated.

CPT® code 61800 is used for the application of a stereotactic headframe for immobilization during stereotactic radiosurgery, and does not include the removal (which typically is performed by the radiation oncologist after treatment delivery). The removal (if performed by a physician other than the one who placed the headframe) is coded separately using 20665 *Removal of tongs or halo applied by another physician.*

Spinal Lesions: Once per Course

Do not report CPT® code 63620 used for spinal lesions more than once per course of therapy. Code 63621 cannot be reported more than once per lesion, and no more than two times over the entire course of therapy regardless of the number of lesions treated, according to CPT® instruction.

For example, a patient presenting with three multiple myelomas of the spine: one 1.5 cm, one 2.0 cm, and the third 3.0 cm. The patient received fractionated stereotactic radiosurgery three times per week for two weeks. Correct coding is 63620-63621 x 2.

Note: The spinal codes do not distinguish between "simple" and "complex" lesions, as do the cranial codes discussed above.

Radiosurgery Bundles Variety of Services

Unlike the radiation oncology codes, which break many services out separately, the radiosurgery codes include services such as treatment planning, dosimetry, targeting, blocking, and positioning. The neurosurgeon who reports the stereotactic radiosurgery codes, should not report codes from the radiation treatment management code series (77427-77435).

When coding services for both the neurosurgeon and the radiation oncologist, remember each specialty has its own set of codes to capture radiation treatment management. Medical record documentation must indicate clearly who performed the services, and care must be taken to ensure the same services are not billed by both departments under the same codes. CE

Janice G. Jacobs, CPA, CPC, CCS, ROCC, is a director in Huron Consulting Group's Life Sciences Advisory Services Practice with over 25 years of health care billing, coding, and reimbursement experience. During her career, she has performed documentation, coding, billing, and charge description master (CDM) reviews. She recently served as interim director of coding compliance at a major West Coast academic medical center, where she worked with the Radiation Oncology department. She is a certified public accountant licensed in Pennsylvania, and serves on the National Advisory Board (NAB) of the AAPC.

Pinpoint Common Chiropractic Coding Modality Errors

Determining modality or procedure and supervision or constant attendance can narrow code selection.

By Michael D. Miscoe, JD, CPC, CASCC, CUC, CHCC, CRA

PROFESSIONAL

Those unfamiliar with chiropractic coding often assume there's not much to it. The chiropractic scope of practice varies from state to state, and in many states is quite broad. The chiropractic coder must be knowledgeable about evaluation and management (E/M), electro-diagnostic, radiology, musculoskeletal diagnostic, physical medicine, and manipulative service coding.

With respect to physical medicine services, there are a number of common mistakes. Vague code descriptions may cause confusion. When controlling carrier rules are absent, look to American Medical Association (AMA) clarifications for guidance. Most errors arise from failure to evaluate the nature of the service provided—specifically, whether the service is classified as a modality or procedure. Where modalities are concerned, providers often fail to consider whether the modality requires supervision or constant attendance.

Define Your Terms

First, consider the difference between modalities and procedures, as defined in the Physical Medicine and Rehabilitation section of the CPT® manual. Modalities are "any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electrical energy." Modalities may be classified either as supervised or constant attendance.

A supervised modality "does not require direct (one-on-one) patient contact by the provider," and describes codes 97010-97028. A constant attendance modality "requires direct (one-on-one) patient contact by the provider," and describes codes 97032-97039.

Play it safe: The definitional requirement for one-on-one contact is somewhat misleading because both the AMA and the Centers for Medicare & Medicaid Services (CMS) indicate in a separate clarification that constant attendance can be provided to more than one patient at a time. Taking a literal definition of constant attendance is best; however.

Although we will not address procedures in this article, it's important to know how they differ from modalities. CPT® defines a procedure as "a manner of effecting change through the application of clinical skills and or services that attempt to improve function." This definition specifically describes codes 97110-97546 and 97780-97799. Under CPT® guidelines, all procedures (except 97150 *Therapeutic procedure(s), group (2 or more individuals)*) require direct one-on-one contact by the provider or therapist.

The key to understanding the modality/procedure distinction is two-part. The first part involves what I call "gizmo" analysis. In short, when the physical agent is provided by some device (gizmo), and the clinical skill is limited to determining the device settings and/or the application location and duration, the service is a modality. When the therapy's effect is more dependent on the practitioner's clinical skill (even where a device is used during delivery of therapy), the service is classified correctly as a procedure.

The second distinction is that modality code selection is based on the physical agent used and the performance method. In contrast, procedures are reported based on the therapeutic outcome achieved, rendering the contact necessary for performance largely irrelevant when selecting the appropriate procedure code.

With these definitions and distinctions in mind, let's analyze some common modality coding errors.

Laser Therapy

Laser therapy is a modality (a gizmo delivering the physical agent causing biologic change) and, in most cases, requires constant attendance (someone has to hold the laser probe). Often it is coded incorrectly as infrared therapy. Although the light spectrum is similar, there are two potential problems when using 97026 *Application of a modality to 1 or more areas; infrared* for laser therapy.

1.) Infrared is a supervised modality, whereas laser therapy in most cases requires constant attendance.

Note: This article considers AMA/CPT® guidelines only. Coding may vary depending on the existence of contrary controlling guidance from the carrier, a controlling reimbursement statute, or the inclusion of the S codes in HCPCS Level II by the carrier or the controlling reimbursement statute.

2.) Infrared is a thermal/heating modality, whereas laser is not (unless a Class IV laser is used). The thermal aspect of infrared is not part of the code description; however, *CPT® Assistant*—although not likely controlling—clarifies that infrared is a "Modality which uses light and heat to rinse [sic] the tissue temperature 5 to 10 degrees centigrade in the area of application" (Summer 1995, page 5).

You should report cold laser therapy using 97039 *Unlisted modality (specify type and time if constant attendance)*. As per the code descriptor, document the time of performance. The service can be reported in multiple units where sufficient time is documented.

Many carriers challenge services reported using an unlisted code such as 97039, and may deny payment on the basis that laser therapy is experimental/investigational. Such a determination permits you to bill the patient directly, and lowers the risk that the carrier will demand a future refund on the basis that the service was misrepresented using 97026.

If the carrier has adopted HCPCS Level II private payer S codes into its code set, you would instead report cold laser therapy requiring constant attendance using S8948 *Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes.*

Mechanical/Vibratory Massage

At times, providers use mechanical devices providing vibration/percussion to alleviate paravertebral or other muscle hypertonicity or tension. Devices may be handheld or involve more elaborate tables or chairs. Because these devices are claimed to cause similar therapeutic effects as massage, they often are miscoded as 97124 *Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)*. Applying the above modalities and procedures definitions, however, these services are classified correctly as modalities because the biological change is caused by the physical agent applied (mechanical vibration, percussion), and no particular clinical skill is necessary to achieve this result.

Code 97016 *Application of a modality to 1 or more areas; vasopneumatic devices* is also inaccurate. Although not likely controlling, *CPT® Assistant* (Summer 1995, page 5) advises, "These devices incorporate suction type force to the soft tissues being treated. Vasopneumatic devices are also used to describe pumps that decrease edema in extremity tissues. Examples include the Jobst Pump, Vibromassage, and Interferrential Pump." Although vibromassage might qualify for 97016, *CPT® Assistant* later clarified in a "Coding Consultation: Question and Answers" segment (May 2005, page 14):

Question

"What is the appropriate CPT® code to report for mechanical massage therapy?"

AMA Comment

"From a CPT® coding perspective, no current CPT® code specifically and accurately describes mechanical massage; therefore, code 97039, *Unlisted modality (specify type and time if constant attendance)*, would be the most appropriate code to report for mechanical massage therapy. It would not be appropriate to report code 97124, *Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)*."

Although the AMA appears to contradict itself, the result is accurate. Vibromassage is a suggested example of what might constitute a "pump that decrease[s] edema in extremity tissues." Clearly, it was not envisioned that a vasopneumatic device would be used in the spinal region according to the 1995 publication, and possibly the inclusion of vibromassage as an example in 1995 was erroneous where the guidance published in 2005 is considered. There is little evidence that such devices provide

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

The key to understanding the modality/procedure distinction is two-part. The first part involves what I call "gizmo" analysis ... The second distinction is that modality selection is based on the physical agent used and contact necessary for performance.

a vasopneumatic effect. Breaking the term into its parts and defining each, we find such a device provides some vascular effect using air. Given that air (specifically, air pressure) is the physical agent at issue with 97016, and that mechanical vibratory massage devices use a pure mechanical percussion or vibratory force as the physical agent, it is reasonable to conclude that CPT® 97016 is not the appropriate code for this service.

Even if we conclude such devices are pneumatic, CPT® 97016 is still improper when a hand-held device is used. CPT® 97016 requires supervision, not constant attendance. A hand-held vibratory percussion device requires constant attendance. Because no existing constant attendance code describes the physical agent at issue, 97039 is still correct.

Iontopheresis

CPT® 97033 *Application of a modality to one or more areas; iontophoresis, each 15 minutes* is appropriate for iontopheresis only. *CPT® Assistant* defines iontopheresis as "the introduction of ions of soluble salts into the body by an electric current."

Some providers and coders incorrectly report iontopheresis on the basis of applying topical gels such as Kool Comfort® or Biofreeze® to the skin prior to electric stimulation pad application. The main problem here, despite the absence of ions from soluble salts, is that constant attendance isn't required with this application type. The second, less obvious issue is related to the introduction of ions from soluble salts. McDonald J., Lundgren K., Thieme H., *Clinical Protocols*, page 48 (Clinical Education Associates, 1996) describes this service:

"Direct current has been used extensively to drive ions from the heavy metals into and through the skin for treatment of skin infections or for a counter-irritating effect. There are three techniques of application:

1. An active pad is placed over gauze that is saturated with a solution containing the ions,
2. The active electrode is suspended in a container containing the ion solution, then the part to be treated is immersed in the container or,
3. Special stimulators with a specially adapted electrode containing the treatment ions is positioned as close to the involved tissue as possible. In all cases a large dispersive pad is applied to the patient and the proper polarity of the active electrode is selected based on the polarity of the ions in the solution."

Because there is a significant risk of burning the patient's skin, constant attendance is required. This therapy is used primarily by dermatologists to treat skin conditions, but may be appropriate to reduce inflammation. The variations between this form of therapy and traditional forms of electric stimulation are distinct:

1. Direct current is utilized and is passed from an active pad or electrode through the skin to a diffusion pad. Most forms of electrotherapy involve alternating current flow between two or more pads where each is an active pad.
2. Special pads containing the treatment ions are used, or a pad placed over gauze saturated with a solution containing the ions is used.
3. True iontopheresis requires constant attendance based on the patient's risk of being burned; traditional forms of electric stimulation do not.

Hands-Free Ultrasound

Ultrasound is a constant attendance modality that uses sound waves to increase tissue temperature. *CPT® Assistant* (Summer 1995, page 5) reports, "This modality is used in the treatment of arthritis, neuromas, adhesive scars, and where increasing the tissue temperature is the desired effect."

Continuous ultrasound (97035 *Application of a modality to one or more areas; ultrasound, each 15 minutes*) clearly provides such a thermal effect, while pulsed ultrasound generally is considered a non-thermal form. Continuous vs. pulsed forms of ultrasound raise interesting coding issues. Consider the description of pulsed ultrasound in *Clinical Protocols*, pages 89-101:

"Soundwave propagation is intermittent, retaining the mechanical effects of mild cavitation and micro massage *without any thermal effects* [emphasis added]. Pulsed ultrasound is beneficial in acute conditions, inflammatory responses, nerve entrapment and neuromas in scar tissue."

Because of the lack of thermal effect with pulsed ultrasound, questions arise regarding the need for or provi-

sion of constant attendance. Currently, some pulsed ultrasound units are marketed as hands-free devices. The ultrasound head is on a mechanical arm placed over the patient. Even when argued that pulsed ultrasound can provide or is providing some thermal effect, if the therapy can be or is delivered in a supervised setting, 97035 is inappropriate. In these cases, constant attendance is not required. When ultrasound can be provided in a supervised setting, report 97039.

Phonopheresis

Phonopheresis is often misreported as an unlisted procedure (97039) on the basis that it is not a modality per CPT®. Phonopheresis is simply a fancy word for ultrasound where a steroidal cream is used in place of the usual conductive gels. *CPT® Assistant* (Summer 1995, page 5) advises, "If ultrasound therapy is used with a steroid cream, 99070 should be added, in addition to 97035, for use of the steroid cream."

Either way, ultrasound (97035) is reported, assuming constant attendance is required and maintained. The only difference is the separate reporting of the steroid cream using the generic supply code 99070 *Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided).*

Although CPT® definitions and clarifications found in the *CPT® Assistant* are not part of the Health Insurance Portability and Accountability Act (HIPAA)-mandated code set, application of these basic principles of modality analysis provide a sound foundation for code selection. Always be on the lookout for differing carrier standards, and follow written carrier guidance. CE

Michael D. Miscoe, JD, CPC, CASCC, CUC, CHCC, is president of Practice Masters, Inc. and the founding partner of Miscoe Health Law, LLC, a member of the AAPC Legal Advisory Board (LAB) and a past member of National Advisory Board (NAB). He is admitted to the Bar in the state of California and to practice law before the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. Mr. Miscoe has nearly 20 years of experience in health care coding and over 14 years as a compliance expert testifying in civil and criminal cases.

Take Four Steps Toward Preventive Medicine Coding Success

By Beverly Welshans, CPC, CPC-I, CPC-H, CCS-P

Follow a few simple rules to prevent a lot of headaches when coding preventive medicine services.

APPRENTICE

The same care your providers take when administering preventive care to assure all has been covered must be taken when coding those services, as well. It never hurts to follow four simple rules that prevent denials on your preventive care claims.

Rule 1: Diagnosis Must Match Reason for Visit

Always match preventive medicine codes with an appropriate diagnosis. This means report a V code—even for Medicare patients.

Remember: The ICD-9-CM diagnosis code always should identify correctly the chief reason for the visit. A preventive medicine service is not a problem-oriented visit, so don't code it as one. Instead, use an ICD-9-CM code to support the services provided (e.g., V70.0 *Routine general medical examination at a health care facility for adults, V72.31 Routine gynecological examination for gynecologic exams* and *V20.2 Routine infant or child health check for well-child care.* Additional special screening codes (V73.0-V82.9) also may be used, as appropriate.

Rule 2: Follow "Three-Year Rule" for New vs. Established

CPT® includes two subsets of preventive medicine codes: 99381-99387 for new patients and 99391-99395 for established patients. The distinction between new and established follows the standard three-year rule. Specifically, if the patient has never been seen, or was not seen by you or anyone else in your group within the past three years, the patient is new. All other patients are established.

Tip: CPT® Evaluation and Management (E/M) Service Guidelines include a "Decision Tree for New vs. Established Patients" to help determine if a patient is reported as new or established.

The new and established patient codes are divided further by patient age:

- Younger than 1 year: 99381 (new) and 99391 (established)
- 1-4 years: 99382 (new) and 99392 (established)
- 5-11 years: 99383 (new) and 99393 (established)
- 12-17 years: 99384 (new) and 99394 (established)
- 18-39 years: 99385 (new) and 99395 (established)
- 40-64 years: 99386 (new) and 99396 (established)
- 65 years and older: 99387 (new) and 99397 (established)

Rule 3: Patient Age and Gender Determine Preventive Service Content

Preventive medicine services always include a comprehensive history and examination, and age-appropriate anticipatory guidance. The comprehensive examination is not held to the rigid "two bullets from each of at least nine body systems" required in a standard *1997 Documentation Guidelines for Evaluation and Management Services* multi-system exam; rather it reflects the required assessment based on the patient's age and gender. The focus of services rendered to a one-year-old infant, for example, will differ from those provided to a 28-year-old woman.

Services for a young child assess physical growth (height, weight, head circumference) and development milestones (speech, crawling, and sleeping habits). Anticipatory guidance includes car seat use and other safety issues, introducing new foods, etc.

An adolescent preventive service may include a scoliosis screen, growth and development assessment, and immunization review. Anticipatory guidance will focus on developing good health habits and self-care, including possibly a discussion of drugs, alcohol, and tobacco; sexual activity; and other peer pressure issues. Educational activities and social interaction are discussed and encouraged.

In the adult population, the same principles apply. A comprehensive preventive visit for a female patient

The distinction between new and established follows the standard three-year rule. Specifically, if the patient has never been seen, or was not seen by you or anyone else in your group within the past three years, the patient is new. All other patients are established.

includes a gynecologic examination, Pap smear, and breast exam. An adult male's exam includes an examination of the scrotum, testes, penis, and the prostate for older patients. (It is not appropriate for a provider to separate these services into a second visit for either patient.) Anticipatory guidance is focused on health maintenance issues: alcohol and tobacco use, safe sex practices, nutrition, and exercise. The patient's employment status and other family issues that may arise are discussed. As a patient grows older, cholesterol levels, blood sugar, and prostate-specific antigen (PSA) testing come into play. This is also the time to address advance directives with the patient.

Rule 4: Separate Services/Procedures Call for Separate Reporting

A preventive visit includes routine screenings such as a tuning fork hearing assessment and a visual acuity screening. Many other services that may be provided at the time of a preventive visit, however, are not included.

The immunization supply and administration laboratory and radiology services, electrocardiograms, and other services with an identifiable CPT® code can be billed in addition to the appropriate preventive service visit code. Remember to append modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service* in this scenario, to identify the preventive medicine E/M service as separate and distinct from other procedures or services provided to the same patient on the same day.

For example, a 45-year-old established female patient presents for her annual physical examination. While there, she complains her left ear feels "plugged." During the course of the history and physical (H&P), the provider observes significant cerumen buildup, and has the nurse flush the patient's ears. In this situation, both services may be billed with a modifier 25 appended to the annual physical (i.e., 99396-25, 69210 *Removal impacted cerumen (separate procedure), 1 or both ears*).

What if, during a preventive visit, a new problem is encountered or an existing problem requires attention? The American Medical Association (AMA) gives direction for these occasions in the CPT® guidelines, as follows:

"If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported."

Remember: In a case such as this, you would append modifier 25 to the office visit code.

"Significant" is the key word here. A preventive visit requires a comprehensive history and examination of the patient. Any work done to support the additional E/M code has to be above and beyond what is already documented to support the preventive code billed. If the criteria are met and an E/M office visit code is billed, be certain to provide an appropriate ICD-9 code to support the additional service.

For example, a 19-year-old established male presents for his annual physical. He asks the provider to look at his right ankle. He states he twisted it snowboarding last night, and it is "killing him." In addition to performing a routine H&P, the provider conducts an expanded problem-focused history relevant to the injury, and performs an expanded problem-focused knee exam. The provider diagnoses an ankle sprain, but wants to rule out a fracture. He orders an X-ray and instructs the patient to rest, apply ice, and elevate the ankle. The provider then writes a prescription for pain medication and tells the patient he will be contacted with the X-ray results.

In this situation, both the annual physical, 99395 with V70.0, and the appropriate level E/M office visit code (for example, 99213-25) with diagnosis 845.00 *Sprains and strains of ankle, unspecified site* may be billed. CE

Beverly Welshans, CPC, CPC-I, CPC-H, CCS-P, is compliance coordinator for University Orthopaedics, University Family Medicine, and University Physical Medicine & Rehabilitation Services at the State University of New York (SUNY) Buffalo School of Medicine. She has held numerous officer positions in her local chapter, and serves on the National Advisory Board.

PROFESSIONAL

Don't Let Vaccines Poke Holes in Your Practice's Pockets

Administer the correct codes to keep reimbursement healthy.

By Lisa Jensen, MHBL, FACMPE, CPC

Each year, a team of top disease experts and practice physicians work together to decide what changes will be made to the childhood immunization schedule, which helps protect U.S. children and adults from diseases. The schedule (www.cdc.gov/vaccines/recs/schedules/child-schedule.htm#printable) is evaluated based on the most recent scientific data available. Changes are announced in January and approved by the American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention (CDC), and the American Academy of Family Physicians (AAFP). Providers receive notice of the changes, and are expected to purchase and administer the immunizations to fit the new schedule.

Over the last several years new and expensive vaccines added to the schedule for adolescents, adults, and children have created a financial hardship for providers trying to balance economic pressures and best practices. A survey commissioned by the National Vaccine Advisory Committee (NVAC) reported that 62 percent of decision makers in practices delayed purchase of a vaccine some time within the past three years due to financial concerns. The survey revealed that in the prior year 16 percent of practice decision makers seriously considered stopping vaccinations for privately-insured patients due to high cost and reimbursement issues.

Offset High Costs with Appropriate Billing

How can practices continue to protect the communities they serve, prevent disease outbreak, and maintain financial viability? One way is to report the vaccines and vaccine-related services accurately, and bill appropriately. You should report vaccine administration using two families of CPT® codes: One for the vaccine itself and one for the vaccine's administration.

To facilitate immunization reporting, the most recent new or revised vaccine product codes, resulting from recent CPT® Editorial Panel actions, are published on the American Medical Association (AMA) CPT® website on July 1 and Jan. 1 in a given CPT® cycle. These dates correspond with CPT® Editorial Panel meetings for each CPT® cycle (June, October, and February).

Watch for a lightning bolt symbol that was added to CPT® in 2006 for vaccine codes pending approval from the Food and Drug Administration (FDA). A full list is in Appendix K. These are normally not reimbursed until the FDA approves the vaccine but have been assigned codes pending approval, which often happens during that CPT® cycle.

Correct Vaccine Reporting

Use CPT® code range 90476-90478 to report the vaccine or toxoid product only, based on the produce manufacturer and brand, the specific schedule, chemical formulation, dosage, patient's age, and/or route of administration. The exact vaccine provided must be reported this way to meet the requirements of immunization registries, vaccine distribution programs, and other reporting systems that track usage and administration of vaccines.

With the dizzying array of vaccine producers and product names, it's challenging to keep the CPT® and ICD-9-CM codes straight. The AAP provides a free table with an easy-to-follow format allowing coders to access the correct CPT® and ICD-9-CM code by knowing either the manufacturer or brand name. This resource can be found on the AAP website at http://practice.aap.org/content.aspx?aid=2334&nodeID=2002.

Be Cautious with Combination Doses

Codes are available for either individual vaccines or combination vaccines. Combination vaccines are formulations of antigens that combine multiple vaccines into a single injection (for example, 90707 *Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use*). It is *not* appropriate to report the components of a combination vaccine when a single CPT® code exists to report the combination.

Report Vaccine Administration Separately

CPT® code range 90465-90474 reports the administration of the vaccine. Report these codes separately from the CPT® code representing the vaccine product itself. These codes are reported based on the route of immunization, the patient's age, the number of injections, and the product administered.

Each family of codes contains a code for the "first" or "one" immunization administration.

CPT® codes 90465 *Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day* and 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* are reported for the first vaccine administered by the injection route to a patient on a calendar date.

Codes 90467 *Immunization administration younger than age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/*

toxoid), per day and 90473 *Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)* are reported for the first vaccine administered by the oral or intranasal route to a patient on a calendar date.

Coding Quandary: Two Different Routes on the Same Calendar Date

Confusion arises for both payers and providers when the patient requires multiple vaccines on the same date, but administered via different methods. In this scenario, report one vaccine administration code that indicates "first," and report the other route as an additional vaccine.

For example, a patient is receiving injectable hepatitis B vaccine and intranasal influenza vaccine. Report the vaccine administration using 90471 and +90474 *Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).*

Physician Face-to-Face Vaccine Counseling

CPT® contains pediatric-specific vaccine administration codes (90465-90468) with special requirements. To report 90465-90468, the patient must be younger than eight-years-old and the physician must perform face-to-face counseling personally. These special codes include the provider work of discussing risks and benefits of the vaccines, the cost of the nursing time to record and give the vaccine, plus the supplies associated with vaccine administration. To support these codes, the medical record must include the physician's personal involvement in the parent/family counseling about the vaccine's risks and benefits.

If the patient is eight years or older, and/or the physician does not personally perform the face-to-face counseling, report a CPT® code from range 90471-90474.

In CPT® 2009, the AMA clarified that vaccine counseling is not included in the Preventive Medicine Visits code range 99381-99397. The CPT® book instructs coders to report immunization and vaccine risk/benefit counseling separately when performed on the same day as a preventive service.

If your practice is having trouble getting the vaccine counseling/administration codes reimbursed with other services, the Childhood Immunization Support Program (CISP) site, in cooperation with the AAP, provides information that you can share with your payers, explaining the vaccine work that is and is not included in the reimbursement for other services. Find the link at www.aap.org/immunization/pediatricians/immunizationcongress.html.

Coding Example:

A six-month-old patient presents to your practice requiring a diphtheria, tetanus toxoids and acellular pertussis vaccine (DTaP), a Haemophilus influenzae type b (Hib), pneumococcal (PCV), and annual influenza. The parent has read a disturbing article in a magazine regarding the risks of (DTaP) vaccines, and your provider must spend time face-to-face with the parent addressing DTaP concerns, and providing additional risks/benefits discussion. The nurse provides the information sheet and additional discussion specific to the Hib, PCV, and influenza vaccines.

Coding for this service would be:

90700 *Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use.* This code is for the DTaP vaccine product.

90465 This code is for the immunization administration of the first vaccine including face-to-face counseling with the provider.

90645 *Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use.* This code is for the Hib vaccine product.

+90472 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).* This code is for the "additional" administration of the Hib vaccine with counseling by the nurse.

90669 *Pneumococcal conjugate vaccine, 7 valent, for intramuscular use.* This code is for the PCV vaccine product.

90472 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).* This code is for the additional administration of the PCV vaccine with counseling by the nurse.

90660 *Influenza virus vaccine, live, for intranasal use.* This code is for the intranasal influenza product.

+90474 This code is for the "additional" administration of the influenza vaccine by intranasal route.

Vaccines for Children (VFC) Program

Since its inception, the VFC Program has helped shift the nationwide vaccine delivery system away from public health and more toward private providers. VFC has accomplished this by providing free vaccines to primary care physicians, attempting to keep children in their "medical home" (their regular source of primary care), with the goal of decreasing private provider patient referrals to public health for immunizations.

Free vaccines are available to children who are under 19 years of age, and who meet any of the following criteria:

- Enrolled in the Medicaid program
- Do not have health insurance
- Have no coverage of immunization on their health plan
- Are American Indian or Alaskan Native

VFC vaccines are provided free to participating physicians, and patients/insurers can only be charged for the administration. Providers bill according to CPT® codes based on each vaccine (type of immunization) administered. Reimbursement through Medicaid varies by state. Some state Medicaid agencies reimburse a vaccine with multiple antigens at a higher rate than a single antigen vaccine. Some states limit the amount of administration fees reimbursed per visit. Check with your state Medicaid agency to determine how the VFC administration fees should be coded and reimbursed. This program is a good way to provide important immunity while preventing reimbursement problems.

Diagnostic Coding

The diagnosis code accompanying the vaccine administration and vaccine product CPT® code typically is specific to the disease for which the patient is being inoculated, from range V03-V06. Some payers only require the diagnosis V20.2 *Routine child health exam* or V20.31 *Health supervision for newborn under 8 days old* or V20.32 *Health supervision for newborn 8 to 28 days old* if the vaccines are administered as part of a complete physical on the same calendar day.

There are many reasons why an immunization may not be given, but the ICD-9-CM book has in the past only provided coders with a single code. Tracking why an immunization was not given can be as important as tracking those that are given. The AAP has requested and recently received additional codes to identify the different reasons why a patient did not receive a routine immunization. Be sure to indicate these circumstances in your practice when they apply:

V64.00 Vaccination not carried out, unspecified reason

V64.01 Vaccination not carried out because of acute illness

V64.02 Vaccination not carried out because of chronic illness or condition

V64.03 Vaccination not carried out because of immune compromised state

V64.04 Vaccination not carried out because of allergy to vaccine or component

V64.05 Vaccination not carried out because of caregiver refusal

V64.06 Vaccination not carried out because of patient refusal

V64.07 Vaccination not carried out because for religious reasons

V64.08 Vaccination not carried out because patient had disease being vaccinated against

V64.09 Vaccination not carried out because of other reason

The nation's providers are soldiers in the campaign to vaccinate America's citizens, but the soaring cost and rising number of new vaccines make it difficult for them to buy the shots that are often underreimbursed. With correct coding and accurate billing of all services rendered, coders can be an important part of keeping their patients healthy. CE

Lisa Jensen, MHBL, FACMPE, CPC, is the manager of the Special Investigations Unit at Providence Health Plans in Beaverton, Ore. She holds a master's degree in Healthcare Business Leadership, has been a CPC® since 1996, and attained Fellowship status in the American College of Medical Practice Executives (FACMPE) in 2008.

AAPC Code of Ethics

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

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

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

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

American Academy of Professional Coders

Wear Your Colors in Nashville

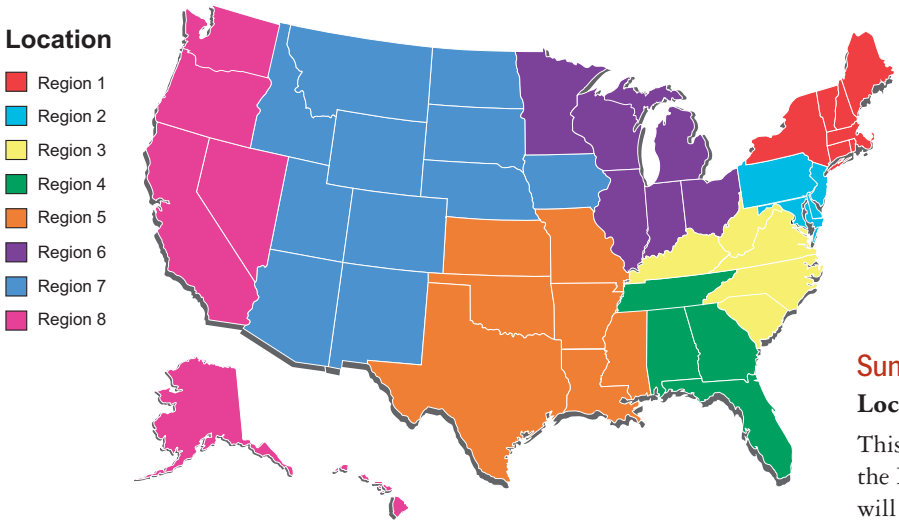
Get excited about the AAPC 2010 National Conference in Nashville, June 6-9 through a little friendly competition, region to region.

AMERICAN ACADEMY OF PROFESSIONAL CODERS
CHAPTER ASSOCIATION

The AAPCCA Board of Directors invites you to the "Wear Your Regional Color" competition at the Member Appreciation Luncheon, Tuesday, June 8.

What is the "Wear Your Regional Color" competition? Each region of the country has a "color."

Be creative. Be adventurous. Be bold.
Just be in your regional color.
Don't know your regional color?
Don't worry. Ask your chapter officers at your next meeting.



2010 National Conference: Memories in the Making

Nashville hosts a new conference experience.

By Region 5 Representatives Wendy Grant, CPC, and Diana Yates, CPC, CPC-H, CPC-I, CPEDS

The 2010 AAPC National Conference will be held June 6-9, in Nashville, Tenn. and the American Academy of Professional Coders Chapter Association (AAPCCA) board wants to add it to your list of unforgettable memories. Our goal in Nashville is to provide attendees and local chapter officers a conference experience unlike any other.

One of the primary functions of a conference, other than to learn and discuss coding, is to promote networking. This year, the AAPCCA board makes it easier to meet others from your area. Throughout the conference, your regional AAPCCA representatives will be wearing purple shirts with coordinating bandanas. To locate your representative, find your region's color on "Your AAPCCA Board" map.

Another welcome addition is the AAPCCA booth, set up in the main foyer of the conference center. This booth will be open daily. Here you will find a representative from your region to discuss local chapter issues, to provide guidance in using the AAPC website, and to give a welcoming smile. Come by and say "Hello!" to a regional rep.

We are honored to present new additions to this year's agenda, which is full of new and exciting sessions, networking opportunities, and individual fulfillment. The schedule of AAPCCA events is:

Sunday

Local Chapter Officer Meeting: 10 a.m.-1 p.m.

This year, the AAPCCA conference committee extends the Local Chapter Officer's meeting to three hours. There will be break-out sessions specific to officers and potential officer needs. If you've ever thought, "I wonder if I should become an officer," these are the sessions for you.

All current officers are encouraged to attend this meeting.

Hour one: You will want to participate in a question and answer session concerning officer-specific needs and duties. Attendees will be grouped by officer title.

Hour two: Everyone unites for the helpful session on "How to Handle Difficult Situations in a Chapter Setting."

Hour three: Learn how to take baby steps out of your comfort zone to become a chapter leader.

Although these sessions relate to the operation of local chapters, attendance is not limited to current officers. If you are curious about becoming a local chapter officer, these sessions are for you. Serving as an officer is both an honor and a privilege. You are necessary for local chapter success.

Meet Your Local Chapter: 4-6 p.m.

Meet officers from chapters all around the country. This is the perfect place to get new ideas, network and see what is going on in other chapters. You will also want to stop by the AAPCCA Board of Directors' table and introduce yourself to them.

Tuesday

Awards Luncheon

The awards banquet on Tuesday is being dubbed "Wear Your Region Color." All award banquet attendees are encouraged to wear their region color to this event. An acknowledgement will be awarded to the region that provides the most spirit throughout the conference. Show up, dress up, and make it a colorful event worth remembering.

Whether this is your first AAPC National Conference or your sixth, this year will be one of the most memorable and enlightening opportunities yet. Please come and experience a new and exciting conference we created just for you. Come revel with others who share a passion and joy for our profession. See you in Nashville. CE

Ride the Convention Bus
for CEUs, Discount, and Rest

Get first-class style on the Nashville conference coding express.

Wouldn't it be nice to go to the AAPC National Conference in Nashville, June 6-9, without costly, inconvenient travel arrangements? Flying is expensive, and you have to deal with airplane security and cramped seating. Driving is stressful and gas is expensive, too. Now imagine comfortable, worry-free travel with your coding colleagues and friends en route to conference. A pipe dream? Hardly.

Let AAPC Do the Driving This Year

Ride first class to conference in one of 19 motor coaches boasting reclining bucket seats, rest rooms, TVs, and a DVD player. Along the way, enjoy professional and personal networking—one of the best parts of being an AAPC member—and laugh, picnic, rest, and play cards or bingo with other coders from your area and chapter.

Less expensive than airfare, buses allow members faced with increasingly tight budgets to attend the Nashville conference—and you don't want to miss this one.

"AAPC members and staff will gain from some truly valuable presentations on coding, billing, compliance, electronic medical records, and ICD-10 implementation," AAPC's conference director, Melanie Mestas, told *Coding Edge*. "It will be our best conference, yet."

Cost, comfort and companionship aren't the only benefits to bus riding. "What better way to hold a chapter's June meeting than on a bus with colleagues and friends?" Marti Johnson, director of local chapters asked *Coding Edge*. Chapters holding meetings on the buses can award CEUs.

Destination: Coding Excellence

Once at conference, members can network with more than 3,000 peers from throughout the world, see what other chapters are doing, and browse the exhibit hall, Mestas said.

Sessions will be broader this year, Mestas said. Coding topics within several specialties—such as primary care, interventional radiology, orthopaedics, urology, plastic and reconstruction, neurology, and radiology—will be covered. Several presenters plan to share advanced coding skills regarding chronic care, diagnosis, modifiers, ethics, and others. Auditing, which is even more important than ever, will be addressed by speakers giving guidance on investigations, recovery audit contractors (RACs), Medicare integrity contractors (MICs), voluntary refunds, compliance plans, and electronic medical records (EMRs). Several facility presentations also are scheduled.

Eight physicians will lead the popular Anatomy Expo, demonstrating through props, video and other means. Specialties and body parts will be covered including cardiology, cardiovascular, obstetrics and gynecology (OB/GYN), hand, podiatry, plastic and reconstructive surgery, and the knee.

Don't forget the magnificent venue. The Gaylord Opryland Hotel is built around three glass-roofed atriums, each of which holds the flowers and trees of a particular biological region of the southern states. Several restaurants, shops, and bars are nestled among the trees and flowers giving attendees a place where they can relax, talk with each other, eye souvenirs, and work.

Sign Up for the Luxury Ride Today

Signing up for the bus allows members to take advantage of the Early Bird Discount until April 15, long after the discount ends on the AAPC website. To take advantage of the $100 Early Bird discount (making the bus trip extremely inexpensive), use the discount code "PRCF#100" when registering. Only those who reserve a bus seat by April 15 will receive the Early Bird savings. CE

Cost, comfort and companionship aren't the only benefits to bus riding. "What better way to hold a chapter's June meeting than on a bus with colleagues and friends?" Chapters holding meetings on the buses will be able to award CEUs.

Find a bus located near you:

Atlanta, Ga.	$105
Birmingham, Ala.	$80
Charleston, S.C.	$135
Charlotte, N.C.	$115
Chattanooga, Tenn.	$80
Chicago, Ill.	$115
Cincinnati, Ohio	$105
Cleveland, Ohio	$115
Columbia, S.C.	$115
Columbus, Ohio	$105
Dallas, Texas	$135
Indianapolis, Ind.	$105
Jacksonville, Fla.	$135
Kansas City, Kan.	$135
Knoxville, Tenn.	$80
Little Rock, Ark.	$105
Louisville, Ky.	$80
Richmond, Va.	$135
St. Louis, Mo.	$105

Find out more on www.aapc.com.

Lives Enhanced by Coding

For many, coding is the turning point toward unlimited opportunity.

By Michelle A. Dick

We've all had it—the moment when we're faced with that instant, unknown opportunity. It usually comes in the depths of crisis, despair, or monotony; and, we can only step into it with trust and courage. Here at AAPC we often hear about someone whose life changed because of becoming a coder and, subsequently, certified. Here are some of those life-changing stories.

Betty Bush, CPC-A

In August 2008, just three days before my 59th birthday, my employer of 20 years handed me a severance letter explaining that my position had been eliminated. I had not seen it coming, and was completely devastated.

The following weeks were a blur of every emotion imaginable—with one dominating thought, "What am I going to do now?" My work experience was in sales and marketing for home building products. Finding a job in that industry was a very slim possibility given the horrible economic state it was in. I didn't think my teaching degree would help me either. My state was cutting positions in education—not adding them. And I was sure my age was going to make finding a job even more difficult.

I spent that fall updating my resume—a daunting task since I hadn't looked at it in 20 years. I then spent three months searching job postings and sending out resumes with no results. It was then I decided to train myself in a new industry: health care. I needed to accomplish that in as short amount of time as possible. A nursing degree would take too long given my age—even a two-year certificate for a technician type position would not work. That's when I found AAPC.

I started by networking through local chapters, sending emails to officers from Charlotte to Raleigh, N.C. I lucked out when one of those emails reached National Advisory Board (NAB) Member Relations officer **Julia Croly, CPC**. We emailed back and forth, and I soon ended up in her office for a face-to-face meeting to learn what medical coding was all about. Frankly, I was surprised that she made time for a total stranger. But we had a great meeting and I left excited about coding and what it could mean for my future.

From there, I just followed AAPC recommendations. I started slowly with medical terminology. I figured if I couldn't handle the "language" there would be no need to go further. But I loved learning the words, and many times said a quiet prayer of thanks to my third grade phonics teacher for doing such a good job. Next was anatomy. This was much more of a challenge, but I now know where everything is, so to speak.

The actual coding course was next. Although somewhat overwhelming at first, I followed the AAPC course module layout one by one and was able to finish the course successfully. In preparation for the certification exam, one of our local chapters gave a review on a Saturday that helped me tremendously. I passed the exam on my first attempt that December.

My path to employment was a bit different. I started volunteering at a large hospital in my state (North Carolina) in July. Luckily, that volunteer experience networked into a full-time job in January 2010. It is not a coding position yet, but when the clinic

interviewed me in early December, I told them about the courses at AAPC and that I hoped to be certified by the end of the year. Once I was hired, my supervisor said they plan to train me as backup for the person currently doing billing/coding for the clinic.

It has truly been an amazing journey. I am proud of my accomplishment and know that with my CPC® credential, I now have something of value in an industry with boundless opportunity.

Jacqueline J. Stack, AAB, CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC, CCP-P

My health care career started just before I graduated from high school. I applied at our local hospital for a position in the registration department. I was fortunate to work that job for 13 years before leaving. Following that, I worked as a receptionist in a small physician office. Later, I worked as a medical transcriptionist. Ultimately, I went back to the original physician office where I worked at the front desk and helped with billing.

In 2004, the small physician practice Seneca Medical Center, LLC (SMC) offered me a biller/coder position. One of the requirements of the job was to become a certified coder. In 2005, after studying for the CPC® exam, I took the test and passed it. At that time, I did not understand much about AAPC, but I soon found this to be the turning point in my life ... Shortly after becoming a CPC®, opportunities to better myself and my career were within my grasp.

I began attending local chapter meetings in my area. I soon learned that attending local chapter meetings offered many benefits. Attending meetings afforded me the opportunity to make friends, gain knowledge from their experiences, and share my experience and knowledge with others. I became secretary/treasurer in 2006, moved onto president-elect, and served as president in 2009.

In 2005, I began attending national AAPC conferences. These conferences are a great place to gain knowledge as well as create a network of fellow coders.

Not satisfied with status quo, I tested and passed several specialty exams; took the PMCC instructor certification; served on the committees to develop the internal medicine and pediatric specialty exams; and in 2007, I went to college.

I attend the University of Phoenix online and plan to graduate in 2011 with a bachelor of science in health administration. I also teach part time at our local university, write articles for magazines, and speak at workshops, local chapter meetings, and conferences. I serve on the AAPC NAB as well.

AAPC provides the opportunity to do the things I love: learn, share my knowledge, and help others succeed.

I still work at SMC, which has grown into a large family practice specializing in occupational health. SMC also has their own hospitalist program and sees patients at many of the local nursing homes. The billing department now consists of five staff members. I do the billing, coding, and physician educating, and I am also the compliance officer.

Becoming a certified coder and joining the AAPC has provided me with many life-changing opportunities. My mentor, another local AAPC member, continues to inspire me. AAPC provides the opportunity to do the things I love: learn, share my knowledge, and help others succeed.

I took the paper home with me that evening and told my husband about it. He looked at it and said, "So, what are you waiting for?" The next day I called and registered.

Shelly Ghrist, CPC

Several years ago, I was managing a local Dollar Tree store and was miserable. Spending so many hours away from my family was making me very unhappy. After 10 years—though I really enjoyed what I was doing—the physical demands of the job and the long hours had taken a toll on me. One day at work, my assistant manager handed me a schedule of classes for returning adult students at the local campus—it was opened to the medical coding course. I looked at it for a few minutes, laid it aside, and went back to work. I took the paper home with me that evening and told my husband about it. He looked at it and said, "So, what are you waiting for?" The next day I called and registered.

I started the classes and was totally overwhelmed. The first class I took was medical terminology and I was sure I would never remember any of those words. I met some wonderful people at that first class, however, and together we made it through. I discovered that I was really enjoying myself. I then moved on to the anatomy class and those same people were there. We again helped each other through the complexities of anatomy. The next class was coding with **Rhonda Buckholtz, CPC, CPC-I, CENTC, CGSC, COBGC, CPEDC**. This class was six hours on a Saturday.

At this point, my district manager at Dollar Tree decided that I had to make a choice between the class and work. I made the choice to continue the class.

After I completed the coding class, Rhonda offered me a position where she was working. After three years with that employer, I did consulting work for a physician for whom I had been working off and on for about two years. What I really wanted to do, however, was start my own billing company. After a few weeks, I received a call from the physician saying that he was in need of a new billing manager. He knew I wanted to start my own business and we discussed some options. He agreed to contract me as a billing company starting Jan. 1. I made a leap of faith and started Ghrist Billing and Consulting, LLC.

I now work from home and visit the physician's office once a week to take care of any issues—and I am in negotiations with two other physicians. The dream of owning my own billing company is now a reality and I love every minute of it.

Once the opportunity pans out, what happens next?

Getting where you want to be career-wise does not happen overnight. There are many opportunities for advancement in the coding field, but to get where you want to be later on down the road, you may have to veer off course. **Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P,** knows this firsthand. "I have taken salary cuts for the opportunity to advance my skills … Sometimes you have to take a step back to take a giant leap forward—take baby steps, pay your dues," Grider said.

"No matter where your career is right now, there are a lot of ways to take the next step," said **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-I, CCC, COBGC,** keynote speaker at AAPC 2006 National Conference, St. Louis. "The key is to challenge yourself to find the things you do best—networking, education, research, compliance, contributing to articles, public speaking, chapter leadership, and participating in project groups."

As coding professionals, "We're lucky to have a career field where there are so many different career options that suit different personalities—capitalize on your strengths and the sky's the limit," said Bucknam. "Look for the opportunities presented to you. Those opportunities may be the turning point you were looking for in your life". CE

[Michelle A. Dick is senior editor at AAPC]

Coders Who Paid Their Dues

These well-known coders' jobs weren't always quite so glamorous.

By Michelle A. Dick

Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P

Worst Job

Directory assistance operator at Indiana Bell (long before the Bell System broke up). The thing I hated about that job was being chained to a telephone directory (literally) and I could not get up from my station until break time. I also hated the supervisors monitoring our calls. Fortunately, I was promoted to a business service representative after one year.

First Coding-related Job

Coder, biller, manager, and other duties as assigned at an ophthalmology group. My boss (a business savvy physician) taught me how to code and how to run a medical office. I loved that job and if the physician I worked for had not told me that it was time for me to move on, I would probably be there still.

Current Achievements

AAPC Vice President of Strategic Development as of May 2009. I am in charge of ICD-10 training, training development, and all new and potentially new areas of health care the AAPC pursues. I participate with CMS on ICD-10 outreach to providers. I testified in front of the National Committee of Health Care Vital Statistics on ICD-10 implementation.

Lynn M. Anderanin, CPC, CPC-I, COSC

Worst Job

The only job I was ever fired from, and my worst job, a sales job selling portrait photography. I do not have the salesperson gene.

First Coding-related Job

Almost 27 years ago, I was hired as a file clerk in a physician's office. Within one year, I was coding surgeries in that office.

Current Achievements

Director of coding for Healthcare Information Services, a physician's billing office and the secretary of my local chapter. I oversee the coding of 20 coders and teach the PMCC course here. I present audio conferences for The Coding Institute (TCI) and AAPC, as well as other workshops and seminars.

Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-I, CCC

Worst Job

Working my way through college on a factory assembly line. I think my worst health care-related job was working for the head of a surgical residency program. The residents brought gross little bits of people in clear cups and put them on my desk for the director. I really hated that; although, it did help me get over being squeamish.

First Coding-related Job

In the '80s physicians started using ICD-9 codes on their claims for the first time ... Because I was the secretary/office manager/transcriptionist for a CT surgery practice, they gave me a CPT® and ICD-9 book and told me I was their new coder. I think that's how a lot of us ended up in coding careers in the '80s, but it was certainly a learning experience.

Current Achievements

Manager of compliance education for a large academic practice group. We have over 1,850 physician and non-physician members in every specialty and over 250 employees. I am responsible for their compliance education. It's really my dream job because I love coding, I love teaching and that's what I do all day.

Carol J. Buck, CPC, CPC-H

Worst Job

Driving a farm-to-market potato truck. I drove alongside a harvester ... I ran into the harvester more than once and banged up both the harvester and the truck. I decided that year I would find a job that did not require me to drive anything.

First Coding-related Job

My first coding job found me. I was employed as an insurance clerk and when the coder moved to another state, the physician assigned that duty to me. I was immediately fascinated with coding and that fascination is still with me today.

Current Achievements

I am learning about ICD-10-CM and the electronic health information systems that are now part of our coding futures. These are exciting times to have a coding career.

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

Worst Job

Downtown deli at age 13 for 50 cents per hour. I manned the cash register, the deli counter, grill, and scooped ice cream. One night, I sliced my finger open on the meat slicer and the boss was at home and would not let me leave to get stitches.

First Coding-related Job

I was hired at what is now Ingenix for the original R & D team to develop the Claims Edit database. I interviewed for another job and did a five minute presentation on coding in hopes I would get hired for studying up on the coding industry. I had never coded in my life. I was well trained over the next five years and absolutely loved it all.

Current Achievements

I am clinical educator for all health information at the University of Utah Hospital and Clinics. I tackle inpatient and facility coding for the outpatient clinics and love all the new challenges. I am on the implementation team for ICD-10. I am excited to put my knowledge of anatomy, physiology, and pathophysiology to good use.

Skin Neoplasm Codes

FIND OUT DIAGNOSIS AND PROCEDURE CODING BASICS FOR SKIN NEOPLASMS.

By Trina Cuppett, CPC, CPC-H and G. John Verhovshek, MA, CPC

APPRENTICE

Coding skin neoplasm diagnoses and excisions requires careful attention to detail. The key to accurate reporting is knowing the sort of detail to look for and where to find it. The following basic guidelines will set you on the right path.

Diagnosis Reporting: Let Path Report Guide You

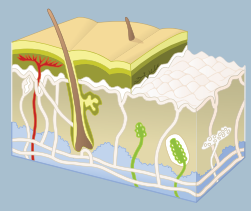
The number one rule of neoplasm coding is, "report only what documentation confirms." Coding a neoplasm diagnosis requires a pathology report—even if the physician knows what kind of neoplasm it is without one. There is one exception to this rule: If a lesion is destroyed with lasers, chemicals, or other methods (such as cryosurgery), a pathology report will not be ordered and the physician's documentation may be used.

The ICD-9-CM Official Coding Guidelines, chapter 2: Neoplasms (140-239), explain: "To properly code a neoplasm it is necessary to determine from the record [specifically, the pathology report] if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined."

ICD-9-CM describes a malignant neoplasm as one of three types (each of which may be reported using a different code):

- **A primary** malignancy is the area (site) where a cancer begins to grow.
- **A secondary** malignancy is one that has spread from the primary site to other parts of the body (for instance, primary lung cancer may spread to bone, and the secondary cancer in the bone will be made up of lung cells).
- **An in-situ** malignancy is confined to its site of origin. These are early-stage tumors that may, however, evolve into invasive malignancies.

Neoplasms not indentified specifically as malignant may be benign (free of cancer) or of uncertain behavior (for instance, showing indications of atypia or dysplasia). Uncertain behavior does not indicate "unknown" or "unspecified;" an uncertain (or benign) designation must be supported by histologic examination. When a pathology report is not available to confirm the diagnosis, however, the neoplasm must be coded as unspecified.



Re-Excision Calls for Original Excision Dx

If the physician excises a neoplasm, then performs a re-excision to remove additional margins at a subsequent operative session, report the same malignant diagnosis linked to the initial excision. The coding is accurate even if the pathology report on the second excision returns benign. *ICD-9-CM Official Coding Guidelines* confirm, "If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis."

Neoplasm Table, Tabular Index Confirms Coding

After you abstract the key information from the pathology report, turn to the Neoplasm table within the index (Volume 2 of the ICD-9-CM manual) to find the appropriate diagnosis. Codes are arranged alphabetically by site, with separate columns for each neoplasm type (primary, secondary, benign, etc.).

ICD-9-CM Official Coding Guidelines instruct, "The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate."

Important: For neoplasms that occur on or near the skin of an anatomic site, assign a diagnosis for skin rather than for the body area in question (for instance, "skin of hand" rather than "hand"). In every case, verify the selected diagnosis by checking the tabular list (Volume 1) of ICD-9-CM before assigning a final code. The *ICD-9-CM Official Coding Guidelines* stress, "The tabular should … be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist."

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

As an example, the physician removes a suspicious mole from the patient's earlobe. The lesion measures 2 cm. The pathology report reveals that the specimen shows an atypical lesion. To find the diagnosis, go to the neoplasm table and look for "neoplasm of connective tissue, ear (external)." Look in the Uncertain Behavior column to arrive at a provisional diagnosis of 238.1. The tabular list confirms that this diagnosis applies to "Neoplasm of uncertain behavior of other and unspecified sites and tissues; connective and other soft tissue."

Procedure Reporting: Type, Location, and Size Determine Coding

CPT® provides different code sets to report excision of benign (11400-11471) and malignant (11600-11646) skin lesions/neoplasms. The codes within each set are differentiated broadly by site (for example, trunk and arms or legs vs. scalp, neck, hands, feet, and genitalia). A quick review is all you need to familiarize yourself with the code organization. Be sure to read the CPT® guidelines in the section carefully.

Most important: Accurate lesion and margin measurements allow for complete and appropriate coding.

CPT® instructions define the excised lesion diameter as the "greatest clinical diameter of the apparent lesion plus that margin required for complete excision." This is equal to the greatest lesion size, plus twice the size of the narrowest margin (the length of the incision used to remove the lesion is not a factor). Note: Base your coding on measurements documented prior to excision (rather than taken from the pathology report, for instance).

For example, a physician removes a lesion from a patient's nose along the supra-alar crease. The lesion measures at 1.5 cm at its widest point and there is an allowance of 1.0 cm margin on all sides. The pathology report later confirms the lesion as benign.

To calculate, consider the narrowest margin (1.0 cm) x 2 = 2 cm. Add this figure to the widest measurement of the lesion (1.5 cm) for a 3.5 cm total. Based on the location of the lesion (nose) and the total measurement (3.5 cm), the correct code is 11444 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm.*

CPT® codes are based on centimeters, so if the physician reports the lesion's diameter in millimeters, you must convert the measurements (for instance, 1 mm = 0.1 cm). Please notice that some codes are reported in centimeters and others are in square centimeter measurements (0.16 sq in = 1 sq cm).

Note: There are plenty of websites (such as www.asknumbers.com) that allow you to easily perform these mathematical conversions online.

For example, if a physician documents a benign lesion excision of the upper arm that is 5 mm in diameter (including margins), this converts to 0.5 cm for CPT® coding accuracy and is reported with 11400 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less.*

Treat Each Lesion Separately

Benign and malignant lesions should be coded separately. Do not add together the excised diameters of multiple lesions as you would the lengths of multiple wounds for wound repair (12001-13160). When reporting multiple excisions, link a separate diagnosis (supported by a pathology report) to each CPT® code. Append modifier 51 *Multiple procedures* to the second and subsequent excision codes (for those payers who accept the codes) at the same location.

For example, a physician removes three lesions from a patient's left shoulder with the following measurements: 2.5 cm (malignant), 1.5 cm (malignant) and 4.1 cm (malignant).

In the CPT® index look up "Excision, Skin, Malignant," which points to the code range 11600-11646. Then, code according to the documented size of the lesions:

11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm

11603-51 Excision, malignant lesion including margins, trunk, arms, or legs excised diameter 2.1 to 3.0 cm

11602-51 Excision, malignant lesion including margins, trunk, arms, or legs excised diameter 1.1 to 2.0 cm

Understanding CPT® and ICD-9-CM coding guidelines for neoplasms is crucial to building your confidence as a coder, and to assuring that you are coding with efficiency and accuracy. CE

Trina Cuppett, CPC, CPC-H, has an associate degree in paralegal technology, which allows her to combine her passion for coding and compliance. She has four years experience as an instructor and is currently in the process of forming a consulting business. Tina has been an AAPC National Advisory Board (NAB) member since 2009.

G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.

Wound Repairs May Be Separate With Lesion Excision

CPT® instructions specify, "The closure of defects created by incision, excision or trauma may require intermediate or complex closure. Repair by intermediate or complex closure should be reported separately" using wound repair codes 12031-13160. Note that the Centers for Medicare & Medicaid Services (CMS) specifies slightly different guidelines per Correct Coding Initiative (CCI) edits, and bundles intermediate and complex closures with excision of 0.5 cm or less. Simple wound repairs are bundled to lesion excision for all payers under CPT® and CMS guidelines.

Look to a future *Coding Edge* for more information on reporting wound repairs.

Coder vs. Machine—10 Rounds in the Ring

Level of service suffers the impact of EMRs' disregard for medical decision making.

By Stephen C. Spain, MD, FAAFP, CPC, and Kathy Rowland, CPC, CEMC, MCS-P

The growing acceptance of electronic medical records (EMRs) continues to affect auditing services in new and significant ways. The number of our clients who use EMRs is on the rise, and recently we've encountered groups who increasingly rely on computerized selection of evaluation and management (E/M) level of service codes. Such audits provide an opportunity for a "head-to-head" comparison of conventional coding principles versus computerized coding systems that select level of service codes based on user input.

EMRs Promise Level of Service Code Accuracy

Like many providers and practices who have invested in EMRs, most of our clients were promised savings in processing and staffing, and improved reimbursement and charge capture. Within a year or two of adopting an EMR, some groups are secure enough to hand over the reins of code selection. This decision generally is made, in part, to allow the organization to realize fully the upside reimbursement potential of an EMR. Reliance upon the EMR's selection process often is encouraged, if not urged, by EMR vendors.

Most EMRs can tabulate exam and history bullets to assign a level for these two key service elements. Software programs generally are incapable of calculating medical decision making (MDM) estimates, however. As part of the encounter documentation, most EMR systems require the provider select the MDM level. When the EMR has all the information, clients are told the software engine will assign the correct level of service code to the encounter.

So far, this sounds pretty good. In an ideal situation, the organization provides additional tutorials and coding advice to its providers—particularly, on the subject of calculating MDM correctly. In doing so, a provider group will be on track for a successful implementation of computerized code selection. In practice, unfortunately, problems quickly can ensue from this approach.

MDM Throws the First Punch

Some EMR coding engines can degrade accuracy of the coding process. In most cases, this occurs primarily because the engines often disregard MDM's impact on code assignment, which creates code selection problems for established patient visits. Frequently, software gives numeric values to the history and exam key elements, and then assigns a numeric value to the MDM level inputted by the provider. The engine then assesses these three values.

This system may work well for new patients, where the lowest value of any of the three components would indicate the level of service. For established patients, however, where only two of the three key elements are required, we see many errors in code assignment by software systems.

When looking at three values, a computer algorithm simply has to pick either two values that match or, if none match, the program will pick the middle value. If MDM is a matching value, or is one of the two high-end values, then the code selection is accurate. If exam and history matches, or are the two highest components; however, then the MDM value has no bearing on code selection.

As an extreme example, an established patient with a pinky sprain could generate a level five visit (99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity*) if the provider performs a comprehensive history and exam. Because an EMR allows the

user to enter great amounts of often superfluous data, many visits are over-documented. Across the board, organizations and payers are seeing an alarming shift of level of service codes for established patients toward the comprehensive end of the spectrum. When considering use of an EMR to provide E/M level of service code selection, it is imperative to include coders in the decision-making process so they can test the EMR's system of logic and understand fully its process for assigning codes.

Put Up Your Coding Defenses

To provide a better understanding of our approach to this coding issue, let's look at our auditing practices and MDM. In a general retrospective audit, we typically apply the rules and regulations of the Centers for Medicare & Medicaid Services (CMS) and Medicare intermediaries because we find that these are the most published, most debated, and most vetted guidelines. Often, they are also the most restrictive. In our experience, if a provider is coding in compliance with the policies of CMS and its intermediaries, the encounter record and billed services generally are defensible across the board for all payers.

Coders know the CPT® manual states that only two of the three key elements are required for assessing a level of service for an established patient. Over the years, there has been debate as to whether MDM should carry additional weight for established patient visits as a marker of the overarching criteria of a service's medical necessity. MDM is clearly a limiting factor in new patient code assignment.

In conversations with multiple Medicare medical directors, it has been affirmed to us that MDM is the best key element to base an assessment of medical necessity. One Medicare director wrote "when coding based on Med Necessity, then MDM is often the lynchpin." Some Medicare intermediaries also include in their provider manuals the statement, "MDM is critical in determining the level of service." CPT® clinical examples contain scenarios that can prove to be exceptions to MDM calculating. In our experience, however, if the level of service is supported by the MDM, the provider has a solid foot should any coding challenge arise.

Expose EMR Weaknesses with Audits

We approach our audits with this understanding of MDM and, as a result, we generally find errors with the EMR-assigned E/M level of service for established patients. Coders in a recently-audited organization reported that soon after making a switch to computerized coding, concerns arose that the EMRs were generating level of service codes with a high rate of over-coding errors. Providers who are aware that their EMR-assessed level of service seem too high are concerned. As we have counseled providers on their individual audit reports, many reported to us that they are perplexed to see a software system assign 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed history; A detailed examination; Medical decision making of moderate complexity* when straightforward or low MDM levels were entered.

Occasionally, our clients have their coding staff perform a parallel audit with us—both to affirm our results and to measure their own accuracy and reliability. In cases where an EMR's coding engine was used, we have performed our audit twice: once applying our conventional rules for E/M code assessment, and another time applying the client's EMR's engine logic. These audits and methodologies generally expose computerized selection process inaccuracy. We have found, typically, the EMR engines generate approximately 15-30 percent more coding errors for established patients when compared to conventional auditing tools and coding practices.

Over the years, there has been debate as to whether MDM should carry additional weight for established patient visits as a marker of the overarching criteria of a service's medical necessity.

At a hefty cost to our clients, claims with incorrectly-assigned service levels are re-submitted with corrections, and some reimbursement inevitably is returned to the payers. Fortunately, some of our clients with savvy coding staff identify errors quickly and convince their administration of the value of an outside audit to address their concerns.

Arm Yourself with Knowledge

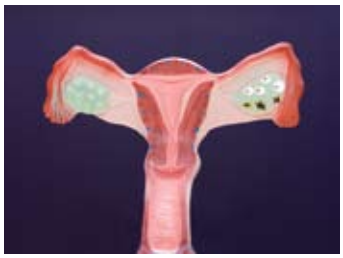
EMR companies are gaining an understanding of the complexity of the MDM issue, and are working continually to improve the code selection process. It is common for software vendors to withdraw enthusiasm for their current engine and promise an imminent upgrade that will enhance accuracy.

As a result of our audits, and usually with the blessing of internal auditors, most of our client organizations have placed the computerized level of service code selection under intense review, or have restored that decision to the authority of providers—putting the organization back in the driver's seat of the code selection process. Hopefully, the education and insight gained through careful coding oversight and auditing services will convince them to keep their hands firmly on the wheel until the promises of future versions and upgrades are proven to be true.

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

Ms. Rowland is a specialist in the development and implementation of practice-based compliance plans. Her compliance experience also includes medical record auditing in many specialties. Ms. Rowland can be reached at krowland@docuchart.com.

Five Common OB/GYN Scenarios Reveal Coding Answers



Face everyday OB/GYN coding challenges with confidence.

By Peggy Stilley, CPC, CPC-I, COBGC, ACS-OB

EXPERT

Are you new to obstetrics and gynecology (OB/GYN) coding? Do you wish you knew some helpful tidbits to ease daunting coding tasks? The following are scenarios most-commonly asked about by attendees during question-and-answer sessions while teaching OB/GYN. These "real world" examples can help you tackle day-to-day coding challenges in your OB/GYN practice.

Scenario No. 1: Preventive Exams—Well Woman

Medicare generally does not pay for preventive exams; however, an allowance was made for the breast, Pap, and pelvic exam (BPP). Medicare pays for a BPP exam every year for those women who:

A.) are of childbearing age and have had an examination indicating the presence of cervical or vaginal cancer or other abnormalities during any of the preceding three years; or

B.) are considered high risk for developing cervical or vaginal cancer.

A high-risk patient is one who has:

- Engaged in sexual activity before the age of 16;
- Had multiple sexual partners (more than five in a lifetime);
- A history of a sexually transmitted disease (including the human papillomavirus and/or HIV infection); and/or
- Had fewer than three negative Pap tests within the previous seven years.

For all other woman, defined as "low risk," Medicare will pay for a BPP exam every two years. An overview of coverage and risk criteria may be found on the CMS website at www.cms.hhs.gov/CervicalCancerScreening/.

To qualify for Medicare coverage, a screening pelvic exam must include at least seven of the following 11 elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;

Pelvic examination (with or without specimen collection for smears and cultures) including:

- External genitalia (for example, general appearance, hair distribution, or lesions);
- Urethral meatus (for example, size, location, lesions, or prolapse);
- Urethra (for example, masses, tenderness, or scarring);
- Bladder (for example, fullness, masses, or tenderness);
- Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (for example, general appearance, lesions, or discharge);
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and
- Anus and perineum.

Reporting and reimbursement for BPP services requires specific HCPCS Level II and ICD-9-CM codes. A full listing of covered HCPCS Level II and ICD-9-CM codes, along with instruction for applying the codes and the minimum exam requirements listed above, is found in the *Medicare Claims Processing Manual*, chapter 18, sections 30 "Screening Pap Smears" and 40 "Screening Pelvic Exams" (www.cms.hhs.gov/manuals/downloads/clm104c18.pdf).

Providers may recommend to a patient certain exams, tests, or services that are not a covered benefit (for instance, the physician may recommend a BPP exam for a low-risk Medicare beneficiary at a frequency greater than two years since the previous exam). It is the provider and staff's responsibility to let the patient know the service may not be covered, or the service has frequency guidelines. Coders must educate themselves: Know which services need an Advanced Beneficiary Notice (ABN), and whether modifiers are required for payment or are informational only. Bookmark the Centers for Medicare & Medicaid Services' (CMS) website in your "favorites" menu, and be aware of local coverage determinations (LCDs) for your Medicare payer.

Scenario No. 2: Global Surgical Package

The services you'll include, or bundle into, the global surgical package will depend on the payer for a particular claim. The global surgical package as defined in CPT® includes:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- One related evaluation and management (E/M) encounter on the date immediately prior to or on the date of the procedure (including history and physical) once the decision for surgery is made

- Immediate postoperative care; including dictating operative notes, talking with the family and other physicians
- Writing orders
- Evaluating the patient in the post-anesthesia recovery area
- Typical postoperative follow-up care

Global days associated with procedures are zero, 10 days, or 90 days. Obstetrical care is defined as global for six weeks past the delivery date.

CMS does not follow CPT® guidelines, however. The Medicare surgical package includes:

- Pre-op visits
  - Day before surgery for 90 day global
  - Day of surgery for 0-10
- Complication following the surgery—unless return to OR
- Post-op visits (related to recovery from procedure)
- Post-surgical pain management provided by surgeon
- Supplies
- Miscellaneous services (dressing changes, staple, drain, tube removal, etc; local incision care, etc.)

So, for instance, whereas a payer who follows CPT® guidelines may allow separate payment for an office E/M service to treat a surgery complication during the global period, Medicare will not allow separate payment unless the patient must return to the operating room.

Be aware of surgical guidelines when contracting with private payers. Inquire whether they follow CPT® or Medicare guidelines.

Scenario No. 3: Endometrial Ablations

Many companies produce a variety of equipment to accomplish ablations. Some instruments incorporate heat, while others use cold. When performing a thermal (heat) ablation, options include loops, roller balls, etc. Thermal ablation may be reported using either 58563 *Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)* or 58353 *Endometrial thermal ablation without hysteroscopic guidance* at any time during the ablation, depending on whether the hysteroscope is used. Cyroablation (use of cold) is reported with 58356 *Hysteroscopic endometrial cryoablation, including endometrial curettage, when performed.*

When reporting endometrial ablations, consider also:

- Any use of hysteroscope can be billed as a hysteroscopic procedure.
- Place of service is critical to reimbursement. For instance, billing 58356 in your office renders 45.55 relative value units (RVUs), while the same procedure performed in a facility is valued at 9.71 RVUs. The higher non-facility reimbursement covers the equipment and administrative costs of running your office.
- National Correct Coding Initiative (CCI) edits apply to Medicare. CCI does not allow the provider to bill separately for anesthesia. Private payers may allow this, however; if so, bill for the para-cervical block (64435 *Injection, anesthetic agent; paracervical (uterine) nerve*).

Scenario No. 4: Urodynamics

With an aging population (and increased public awareness), urinary incontinence is no longer a forbidden topic. Patients are encouraged to discuss their problem, and physicians are educated about testing and surgical options available. CPT® 2010 offered several revisions to urodynamic testing codes, as well as new and "resequenced" codes.

51726 Complex cystometrogram, calibrated electronic equipment

51727 with urethral pressure studies, any technique

51728 with bladder voiding pressure studies, any technique

51729 with bladder voiding pressure studies, urethral pressure studies, any technique

+**51797** Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure). [This code is resequenced as well as revised.]

Urodynamic testing generally is performed by specially-designed equipment (calibrated electronic equipment), which contains graphs and/or images. From those graphs or images, a provider interprets the patient's condition and makes recommendations about treatment, therapy, or surgery that is translated into a written report.

Cystometrogram measures how well the bladder stores and empties urine; for instance, for patients with symptoms of urinary incompetence. The procedure must be performed by, or under the direct supervision of, a physician, with all supplies provided by the physician. If the physician only interprets the results and/or operates the equipment, append modifier 26 *Professional component* to identify the physician's services.

Voiding pressure studies may measure pressure either just in the bladder or in the bladder and abdomen simultaneously (as described by 51797). Subtracting the voiding abdominal pressure from the total bladder pressure on voiding gives the most accurate determination of true voiding pressure, also known as detrusor pressure. As an add-on procedure, 51797 may be reported with 51728 or 51729, which include bladder voiding pressure only. The procedure must be performed by—or under the direct supervision of—a physician, with all supplies provided by the physician.

Scenario No. 5: Adhesiolysis

Lysis of adhesions may be billed separately—either by reporting a separate CPT® code (see below) or by adding modifier 22 *Increased procedural services* to the primary procedure code—depending on the adhesions' extent and based on the procedure's documentation.

Documentation is crucial as the surgeon must describe the adhesions in the same manner that a writer describes a situation in a novel. It must tell a story giving a clear picture describing the difficulty encountered in the procedure. Did the adhesions distort the anatomy? Were they dense and fibrous? How much time was spent removing the adhesions before seeing the surgical field?

For example, the physician's documentation might specify: "There were dense adhesions from the bladder to the uterus appearing to have grown to the patient's uterus from a prior cesarean. These were carefully dissected with the Harmonic scalpel. Approximately one hour of extra operating time was utilized in attempting to dissect the bladder from the uterus. This was very tedious given that the adhesions were so dense and there was not a good operating plane and this made the dissection very difficult."

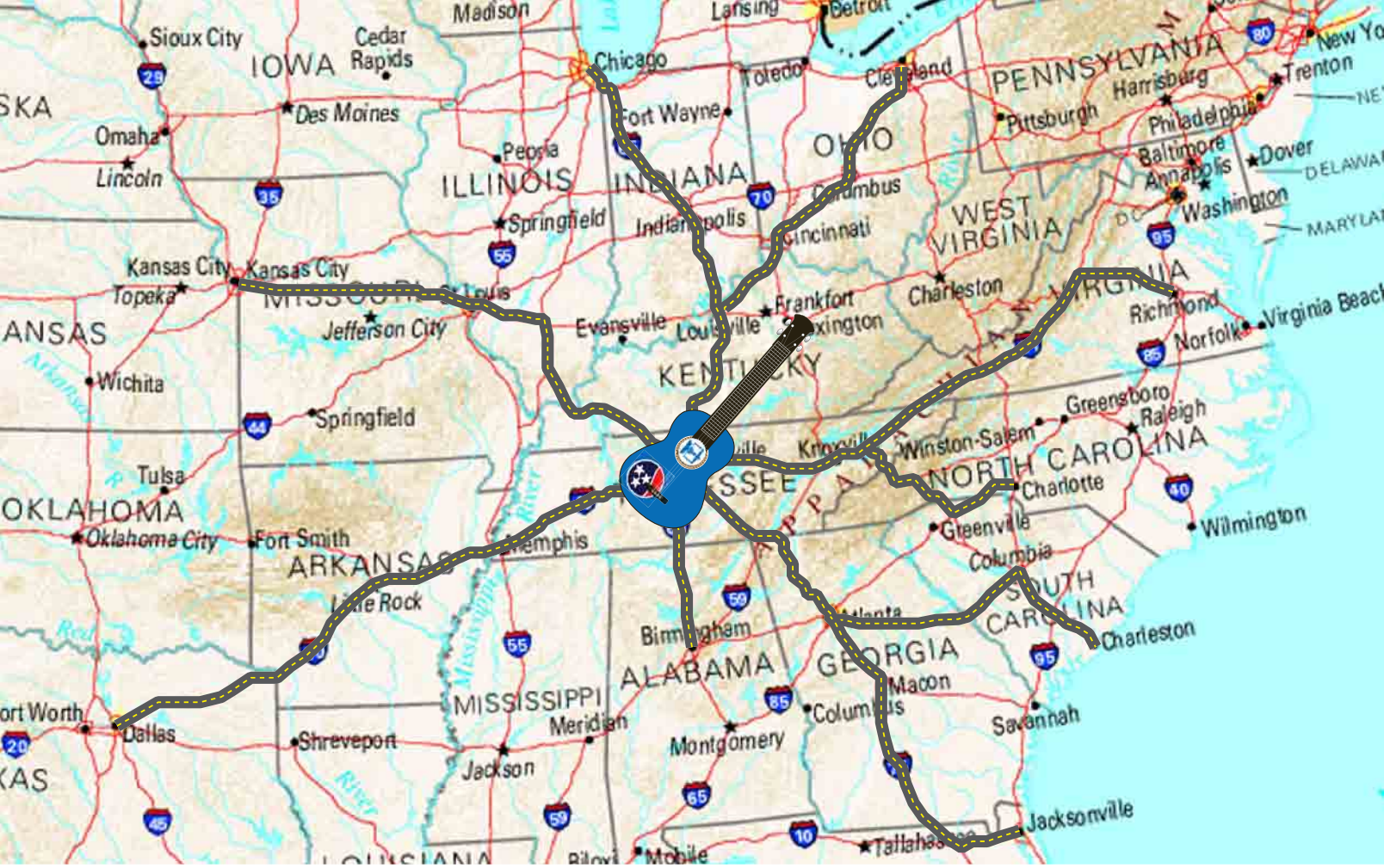
In this case, appending modifier 22 to the primary procedure code is justified, along with a request for additional payment based on the unusually difficult or time-consuming nature of the procedure.

When coding separately for adhesions using a dedicated CPT® code, select an appropriate code based on location:

- Tubes and ovaries, 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)* or 58740 *Lysis of adhesions (salpingolysis, ovariolysis)*
- Peritoneal or pelvic viscera, 58662 *Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method*
- Intrauterine, 58559 *Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)*
- Labial, 56441 *Lysis of labial adhesions*
- Urethral, 53500 *Urethrolysis, transvaginal, secondary, open, including cystourethroscopy (eg, postsurgical obstruction, scarring)*
- Intestinal adhesions, 44005 *Enterolysis (freeing of intestinal adhesion) (separate procedure)* or 44180 *Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)*

For example, significant dense adhesions were dissected from the omentum to the anterior abdominal wall and left pelvic sidewall. In this case, report 44180. CE

Peggy Stilley, CPC, CPC-I, COBGC, ACS-OB, is the clinic manager for OU Physicians, Women's Healthcare in Tulsa. With over 25 years in the medical field, her time at OU has allowed her to use her experience in the clinic to educate faculty, staff, and residents. Peggy is active in her local chapter and serves as president-elect. She teaches AAPC webinars, and is a frequent speaker for The Coding Institute (TCI).



All Roads Lead to Nashville

The AAPC has charted buses from 19 cities to make your trip more affordable:

- Atlanta, Ga.
- Birmingham, Ala.
- Charleston, S.C.
- Charlotte, N.C.
- Chattanooga, Tenn.
- Chicago, Ill.
- Cincinnatti, Ohio
- Cleveland, Ohio
- Columbia, S.C.
- Columbus, Ohio
- Dallas, Texas
- Indianapolis, Ind.
- Jacksonville, Fla.
- Kansas City, Mo.
- Knoxville, Tenn.
- Little Rock, Ark.
- Louisville, Ky.
- Richmond, Va.
- St. Louis, Mo.

Join us for AAPC's 2010 National Conference at the Gaylord Opryland Resort in Nashville, Tennessee. The conference will focus on important changes taking place in the health care industry: ICD-10 implementation, recovery audits, medical record documentation and more.
Seating is limited; reserve your bus ticket by April 15.

2010 AAPC National Conference—The Business Side of Medicine

To register for the conference and reserve your bus ticket, visit aapc.com/nashville

American Academy of Professional Coders

www.aapc.com
1-800-626-CODE

newly credentialed members

Angela Booyep Beninati, CPC Anchorage AK
Shanna L Owens, CPC Anchorage AK
Christina Dixon, CPC Girowood AK
Laura Milazzo, CPC Palmer AK
M Gail Agen, CPC Wasilla AK
Kimberley W Bradley, CPC Birmingham AL
Carrie Michelle Fultz, CPC Deatsville AL
Kimberly D Hall, CPC Dothan AL
Bonnie Edwards Morrison, CPC Dothan AL
Sharon Pate, CPC Evergreen AL
Elaine Brooks, CPC Florence AL
Candice Nicole Hodges, CPC Hayden AL
Lee Horton, CPC Huntsville AL
Jayna L Lacy, CPC Jasper AL
Rhonda S Thompson, CPC Jasper AL
Theodalinda Theriot, CPC Madison AL
Dianne Greene, CPC, CPC-H, CPC-P McCalla AL
Shaundra Anita McLamb, CPC Montgomery AL
Kacey A Calvert, CPC Mount Olive AL
Elaine Holland, CPC Muscle Shoals AL
Sandra Faye Cozad, CPC Oneonta AL
Kara Silvers, CPC Oxford AL
Xenia Schiller, CPC Pelham AL
Jaime Prestridge, CPC Pinson AL
Tara Bishop Grant, CPC Prattville AL
Jerri Thweatt, CPC Tuscaloosa AL
Ginny R Brock, CPC Verbena AL
Ashley Lynn Spiegner, CPC Wetumpka AL
Cindi Burns, CPC-H Winfield AL
Angelita Eileen Salvador Batara, CPC, CPC-H FPO AP
Ramchandra Murthy Puligilla, CPC Hyderabad AP
Sapphira Andrea Frasier, CPC Bentonville AR
Deana Lee Berry, CPC Fayetteville AR
Cody Blake Lowe, CPC Rogers AR
Kelly Hacker, CPC Arizona City AZ
Ashley E Eberle, CPC Casa Grande AZ
Linda Lee Jacovetta, CPC Chandler AZ
Linda M Gourley, CPC Glendale AZ
Kara Sauceda, CPC Goodyear AZ
Heidi Adams, CPC Phoenix AZ
Debra L Alix, CPC, CPC-H, CPC-P Phoenix AZ
Judy Perez, CPC-P Phoenix AZ
Cynthia Rudd, CPC, CPC-P Phoenix AZ
Lana D Thomas, CPC Sacaton AZ
Martin Lee Block, CPC Scottsdale AZ
Aprylll Falcon, CPC, CPC-H Sierra Vista AZ
Karen Sue "Susie" Gray, CPC Sun City AZ
Jennifer L Cicon, CPC Surprise AZ
Pamela Hall, CPC Surprise AZ
Elva D Torres, CPC Tolleson AZ
Barbara E Moore, CPC Tucson AZ
Dana Hasten, CPC Winslow AZ
Angela Galaviz, CPC-H Yuma AZ
Herbert W Loroña Jr, CPC, CPC-H Yuma AZ
Misty Lynn Caraan, CPC Bakersfield CA
Violeta Rumbaua, CIRCC Burbank CA
Jose Rosalex Garcia, CPC Carson CA
Deborah Bibb, CPC, CIRCC Concord CA
Elizabeth A Gomez, CPC Cypress CA
Roxanne Schletter, CPC Daly City CA
Jeannette L Vilan-Cantara, CPC Daly City CA
Kristina Grijalva, CPC Downey CA
Jaime Elizabeth Darling, CPC Escondido CA
Kimberly N Jorgensen, CPC Fresno CA
Anita E Lahodny, CPC Fresno CA
Karey Wall, CPC-P Fresno CA
Barbara J Mathias, CPC Glendale CA
Davina Luciano, CPC Hemet CA
Elizabeth M Slattery, CPC Highland CA
Pauline Judson, CPC Huntington Beach CA

Leticia Juarez, CPC Lake Forest CA
Cecilia M De Leon, CPC, CIRCC Long Beach CA
Sandra Castellon, CPC Los Angeles CA
Nancy Kwan, CPC-H Los Angeles CA
Maureen Wong, CPC Mountain View CA
Claire Anne S Borja, CPC Newbury Park CA
Nova Colleen Morris, CPC Oakland CA
Kelly Burns-Davis, CPC Oceanside CA
Christina Muro, CPC Oxnard CA
Erica Valadez, CPC Panorama City CA
MaryKate Maier, CPC Pleasanton CA
Darlene G Garcia, CPC Rosemead CA
Michelle Martinez, CPC Sacramento CA
Deborah Morrison, CPC Sacramento CA
Taisha A Wick, CPC San Bernardino CA
Amanda Tsuda, CPC San Diego CA
Eduardo Calvo, CPC San Mateo CA
Mona F Falcon, CPC Santa Ana CA
Cynthia Irene Neavez, CPC Santa Ana CA
Paul Donald Aragones Apusen, CPC, CIRCC Signal Hill CA
Gina Marie Dolce, CPC-H Solana Beach CA
Cindy Goldberg, CPC Studio City CA
Yvonne Gomez, CPC Tarzana CA
Victor Arceta, CPC Torrance CA
Chanthaburi Princess Sarin, CPC Torrance CA
Frank M Asi, CPC Valencia CA
Yollete Capalla, CPC, CPC-H Van Nuys CA
Ajith Kumar Kantrapati, CPC Victorville CA
Maria L Hiona, CPC Woodland Hills CA
Donna R Maple, CPC Aurora CO
Sandy Page, CPC Broomfield CO
Scarlet Evans-Cerezo, CPC Colorado Springs CO
Stephanie Kittridge, CPC Colorado Springs CO
Sara Rebeck, CPC Colorado Springs CO
Tabitha Walter, CPC Colorado Springs CO
Deanna Danko, CPC Denver CO
Janice Brooks, CPC Grand Junction CO
Carmella L Ybarra, CPC Highlands Ranch CO
Amie Arias, CPC Lakewood CO
Tawnya Valek, CPC Loveland CO
Beverly Burton, CPC Pueblo CO
Charla Hardy, CPC Pueblo CO
Veronica Seibert, CPC Strasburg CO
Jerome Barbier, CPC Wellington CO
Gwen L Davidson, CPC Yuma CO
Barbara J Hart, CPC Ansonia CT
Maria Lorena Conley, CPC Brookfield CT
Cindy L Girgenti, CPC Danbury CT
Melissa E Scott, CPC Danbury CT
Jason Cavallaro, CPC East Haven CT
Stephanie Lynn Massung, CPC E. Lyme CT
Theresa M Fournier, CPC Griswold CT
June L Nunes, CPC Groton CT
Kimberly D Hall, CPC Guilford CT
Lesa Steininger, CPC Henderson CT
Kelly J Earl, CPC Ledyard CT
Johanna M Ward, CPC Mystic CT
Barbara L Rossignol, CPC, CPC-H New Britain CT
Anne Elizabeth Dutson, CPC New Fairfield CT
Janis Elizabeth Pilla, CPC New Fairfield CT
Serina Anne Rybos-Schultz, CPC New Preston CT
Felicia Cirigliano, CPC Newington CT
Dennis J Kelly, CPC Newington CT
Nancy L Standrowicz, CPC North Grosvenordale CT
Lori Gonsowski, CPC Norwich CT
Jocelyn Marie Nyack, CPC Oakdale CT
Cathy Cassineri, CPC Plainville CT
Kristin Andrews, CPC Ridgefield CT

Sue Hulse, CPC Ridgefield CT
Suzanne Merino, CPC West Hartford CT
Cindy Eleanor Thomas, CPC Washington DC
Adrian Kenner, CPC-H Bear DE
Lisa Michelle Williamson, CPC-H Bear DE
Carol Lynn Heglund, CPC-H Middleton DE
Lisa Smith, CPC-H New Castle DE
Damaris Perez, CPC-H Newark DE
Danielle Tracey, CPC Newark DE
Tanya K Marrero, CPC Wilmington DE
Eileen P Russo, CPC-H Wilmington DE
Dawn L Wing, CPC-H Wilmington DE
Mark R Altenhof, CPC Alachua FL
Donna Williams, CPC Brandon FL
Leslie Rae Herndon, CPC Branford FL
Romana Ruscillo, CPC Cape Coral FL
Lisa Sevick, CPC Cape Coral FL
Jessica Deleo, CPC Cocoa Beach FL
Angela Plouffe Smith, CPC Crawfordville FL
Sheila Rolling, CPC Crestview FL
Kristy Fairchild, CPC Crystal River FL
Nancy Louise Stembridge, CPC Davie FL
Karen Aalbregtse, CPC-P DeLand FL
Patricia Ray, CPC Fleming Island FL
Allison Branyon, CPC Ft Myers FL
Phyllis Koppe, CPC Ft Myers FL
Heather Noughton Bokor, CPC Gainesville FL
Katherine R Lindsey, CPC Gainesville FL
Tracy Lynn Snyder, CPC Gainesville FL
Tracy Wagner, CPC Gainesville FL
David M Wilkens, CPC Gainesville FL
Adilen Castillo, CPC Hialeah FL
Arianne Echemendia, CPC Hialeah FL
Jacqueline Garcia, CPC Homestead FL
Brenda G Bell, CPC Jacksonville FL
Danilo Mira Camacho, CPC Jacksonville FL
Jeffrey Lee Carter, CPC Jacksonville FL
Dianne Colon, CPC, CPC-H Jacksonville FL
Evelyn Henry, CPC Jacksonville FL
Michelle Jones, CPC Jacksonville FL
Judi Pelaia, CPC Jacksonville FL
Mitsy Romero, CPC Jacksonville FL
Kimberly Mccormick, CPC Jacksonville Beach FL
Anita Gordon, CPC Jensen Beach FL
Shannon Crowder Tisdale, CPC Lake City FL
Alicia Tullo, CPC Lake Mary FL
Malinda De Jesus, CPC Land O'Lakes FL
Amanda Seebarran, CPC Largo FL
Phyllis Ann Zellers, CPC Largo FL
Paz Liduvina Beech, CPC Lutz FL
Patricia J Bickel, CPC Lutz FL
Caroline Wardell-White, CPC Lutz FL
Brandi Maxwell, CIRCC Mary Esther FL
Erin Colleen Martin, CPC Melbourne FL
Cathy J Sterling, CPC Melbourne FL
Yahy Aguiar, CPC, CPC-H Miami FL
Brett Lewis Burk, CPC Miami FL
Antonette Cabrera, CPC Miami FL
Ivon Piedad Carralero, CPC Miami FL
Barbara Del Rio, CPC Miami FL
Michele Dubois, CPC Miami FL
Georgina Ferrer, CPC, CPC-H Miami FL
Barbara Gonzalez, CPC Miami FL
Gladys Hun, CPC, CPC-H Miami FL
Isabel I Jurado, CPC Miami FL
Yipsy Martinez, CPC Miami FL
Narci Perez, CPC, CPC-H Miami FL
Yenny Rodriguez, CPC Miami FL
Mercedes Mantilla, CPC, CPC-H Miami Gardens FL
Maria E Collantes, CPC, CPC-H Miami Lakes FL

Dana Eichler, CPC Naples FL
Kristy Marino, CPC Naples FL
Jennifer Sue Barry, CPC Newberry FL
Kiarra Camille O'Neal, CPC, CPC-H North Lauderdale FL
Amber Cook, CPC North Port FL
Denise Leid, CPC North Port FL
Lisa Parker, CPC Ocala FL
Dedan K Munajj, CPC-H Opa Locka FL
Jua'nte DeChelle Williams, CPC Orange City FL
Katherine Alice Dixon, CPC, CPC-H Orlando FL
Demetria McKenzie, CPC Orlando FL
Casey A Petrov, CPC Ormond Beach FL
Josephine M Burke, CPC Pace FL
Rhonda L Hasner, CPC Palm Bay FL
Parul Garg, CPC Palm Harbor FL
Liana Urdanivia, CPC Penbroke Pines FL
Lissette Leon, CPC, CPC-H Plantation FL
Rosario Nunez, CPC, CPC-H Plantation FL
Rhonda L Slay, CPC Ponce De Leon FL
Nikkiann Molnar, CPC Port Richey FL
Patricia Keaney, CPC, CPC-P Reddick FL
Tonya Nichols, CPC Riverview FL
Miranda Jean Fleming, CPC Rockledge FL
Julie Huffman, CPC Sarasota FL
Andrea May Sturm, CPC Sarasota FL
Kathleen R Putney, CPC Sebastian FL
Amanda Halbrook, CPC St Petersburg FL
Victorya Mier, CPC Stuart FL
Vicki J Mildenberger, CPC Tallahassee FL
Jennifer S Plumb, CPC Tallahassee FL
Earleen Lee Chavez, CPC, CPC-H, CPC-P Tampa FL
Joyce Nelson, CPC Venice FL
Leslie J Forrest, CPC Viera FL
Linda Marie Kelly, CPC Walnut Hill FL
Lynn J Brisendine, CPC Williston FL
Linda Carole Armstrong, CPC, CPC-H Winter Park FL
India Louise Wallace, CPC Acworth GA
Ronald E Martin, CPC Atlanta GA
Shawn D Williams, CPC Atlanta GA
Sabra Ramsey Smiley, CPC-H Augusta GA
Vicky Garcia, CPC Ball Ground GA
Bennie Gaskin, CPC College Park GA
Pinkie Taylor Turner, CPC, CPC-H Covington GA
Mary Scalf, CPC Dalton GA
Devon Woolcock, CPC Decatur GA
Edna Kay Bonner, CPC Gordon GA
Laurie M Emert, CPC-H Jonesboro GA
Kimberly Clark, CPC La Fayette GA
Nicole Schmidt, CPC Lawrenceville GA
Tamara Shantreece Lester, CPC Lithonia GA
Julienne Nickole Smith, CPC Lithonia GA
Pamela Terrell Roberson, CPC, CPC-H Mableton GA
Nubian S Gayle, CPC McDonough GA
Dawn Strozier, CPC McDonough GA
Keith Hammonds, CPC Riverdale GA
Troy M Thompson, CPC, CPC-H Riverdale GA
Candice Hester, CPC Savannah GA
Julien Harris, CPC Smyrna GA
Suzanne Blanchard, CPC Stockbridge GA
Jerome Marshall, CPC Stone Mountain GA
Kimberly Michele Thomas, CPC Union City GA
Sherry Marie Henderson, CPC, CPC-H Woodstock GA
Imran Khan, CPC Gurgaon Haryana
Tiana Kamehiro, CPC Honolulu HI
Jeri Leong, CPC, CPC-H, CPMA, CPC-I Honolulu HI

Judy L Johnson, CPC Council Bluffs IA
Tracy Knapp, CPC-H Sergeant Bluff IA
Debbie Guess, CPC Ammon ID
Victoria L Butler, CPC, CPC-H, CPC-P Boise ID
Natalie Jean Cook, CPC, CPC-H Boise ID
Tesja Erickson, CPC Idaho Falls ID
Heather Helene Lee, CPC Lewiston ID
Sandra E Cruise, CPC, CPC-H Meridian ID
Jeanna L Matthews, CPC, CPC-H Nampa ID
Stephanie Larsen, CPC Pocatello ID
Jolene Denise Stewart, CPC Star ID
Tanisha McKenzie, CPC Bellwood IL
Bernadine Szajuk, CPC-H Berwyn IL
Crystal R Alvis, CPC Bloomington IL
Debbie Deprest, CPC, CPC-P, CPC-I Bourbonnais IL
Timothy F McCarthy, CPC Bridgeview IL
Jennifer Lynn Campbell, CPC Chester IL
Zachary Hochstetler, CPC Chicago IL
Pamela Jo Brohard, CPC Decatur IL
Lori Jeanne Durbin, CPC Decatur IL
Karen M Noell, CPC Frankfort IL
Nilam Vaghasia, CPC Glendale Heights IL
Rachel Coon, CPC, CPC-P Lebanon IL
Tammy Beechler, CPC Litchfield IL
Babs Binney, CPC Litchfield IL
Angela Schackmann, CPC, CPC-H, CPC-P Mattoon IL
Traci Stevens, CPC McHenry IL
Becky Hess, CPC Mount Vernon IL
Julie A Tucker, CPC Oak Lawn IL
Bertha Dominguez, CPC Plainfield IL
Tamara Verna Luckey, CPC Plano IL
Sharon Collins, CPC South Beloit IL
Juanita D Fields, CPC South Holland IL
Renee Lynn Andrews, CPC Sterling IL
Brandie L Messer, CPC Stillman Valley IL
Rajeshree Patel, CPC Streamwood IL
Mark Halbach, CPC Urbana IL
Jami Wiese, CPC Urbana IL
Sandy K Woodall, CPC Watson IL
Snjezana M Nikolic, CPC Westmont IL
Ruth Dewitt, CPC Crawfordsville IN
Kimberly Chase, CPC Evansville IN
Dawn Elaine Voris, CPC, CPC-H Fort Wayne IN
Kristen P Frazier, CPC, CPC-H Indianapolis IN
Robin Isom, CPC Indianapolis IN
Lucille Marie Koehl, CPC Indianapolis IN
Teresa Loyd, CPC Indianapolis IN
Suzanne M Rau, CPC Indianapolis IN
Tara Miller, CPC Lafayette IN
Cynthia Stahl, CPC, CPC-H, CPMA, CPC-I Lebanon IN
Jeannie Geerts, CPC Madison IN
Lisa M Smith, CPC Mc Cordsville IN
Kim Greenwell Miller, CPC New Albany IN
Susan Bezy, CPC Pekin IN
Gina Emmenegger, CPC Richmond IN
Sheila Keiser, CPC South Bend IN
Marsha L Duggins, CPC Tipton IN
Michele A Woolum, CPC Versailles IN
Yogesh Kumar, CPC Delhi INDIA
Sanjay Kumar, CPC New Delhi INDIA
Shirley Gamble, CPC Abbyville KS
Diane Stumpf, CPC Auburn KS
Pamela Ackley, CPC Haysville KS
Ali Wenger, CPC Lawrence KS
Jacqueline Felder, CPC Louisburg KS
Deborah Woods, CPC Merriam KS
Robyn R Klein, CPC Overland Park KS
Crystal S Anderson, CPC Topeka KS
Kendall Baker, CPC Topeka KS

Michelle Lynnette Brooks, CPC Topeka KS
Peggy Cain, CPC Topeka KS
Robin Cox, CPC Topeka KS
Becky J Florence, CPC Topeka KS
Lisa Flores, CPC Topeka KS
Cindy Garrison, CPC Topeka KS
Sheila Heiman, CPC Topeka KS
Vanessa Michelle Hetzel, CPC Topeka KS
Melanie Klenklen, CPC Topeka KS
Jessica Powell, CPC Topeka KS
Nicole P Ramer, CPC Topeka KS
Paula L Sperry, CPC Topeka KS
Alycea Lakin, CPC Wamego KS
Bobbie Shannon, CPC White Cloud KS
Stephanie Renee Adams, CPC Wichita KS
Nancy Chapman, CPC Wichita KS
Claudia Alejandra Crowell, CPC Wichita KS
Kathy Ann Kimpler, CPC Wichita KS
Sandra Schmidt, CPC Wichita KS
Jodi Smith, CPC Wichita KS
Kesha Edelen, CPC Bardstown KY
Amanda Gail Cohron, CPC, CPC-H Bowling Green KY
Lela Marie Mason, CPC Corbin KY
Mary M Meehan, CPC Covington KY
Marilyn S McCauley, CPC Lawrenceburg KY
Lydia D Cannon, CPC Lexington KY
Carolyn Murphy, CPC Lexington KY
Brenda J Wallace, CPC Lexington KY
Laleeta R Whiting, CPC Lexington KY
Tiffany Dawn Bridges, CPC London KY
Mary Allen, CPC Louisville KY
Susan Brown, CPC Louisville KY
Paul Cooper, CPC Louisville KY
Eugene D Dean, CPC Louisville KY
Brandi Reinhardt, CPC Louisville KY
Angela Suarez, CPC Louisville KY
Melinda S Gaylor-Martino, CIRCC Morning View KY
Patricia A Samol, CPC Mount Washington KY
Jessica Ann Essenpreis, CPC Oakland KY
Felicia D Vincent, CPC, CPC-H, CPC-P Oakland KY
Lynn Francis, CPC Shepherdsville KY
Michelle Leanne Jensen, CPC Taylor Mill KY
Lynn Michelle Routh, CPC Versailles KY
Vickie S Stechschulte, CPC Versailles KY
Barbara J Armstrong, CPC Whitesville KY
David Lee Carter, CPC Winchester KY
Kristine L Johnson, CPC Winchester KY
Daniel D Konstantopoulos, CPC Winchester KY
Rachel Saune', CPC Covington LA
Barbara Hutchinson, CPC, CPC-H Delhi LA
Susan Smolen, CPC Gretna LA
Samantha Faulkner, CPC Kenner LA
Joyce Price, CPC Kentwood LA
Susan Crescioni, CPC Mandeville LA
Peggy R Salminen, CPC Metairie LA
Lynn Whitfield, CPC Metairie LA
Cindy Vaughn, CPC Mira LA
Mary Anne Keane, CPC, CPC-H Arlington MA
Hollis Bono, CPC Attleboro MA
Jennifer Vasquez, CPC Easthampton MA
Gail Aguiar, CPC Fall River MA
Stacey Lee Santiago, CPC Framingham MA
Michael P Hardiman, CPC Hanson MA
Karin L Benjamin, CPC Haverhill MA
Kathleen A Clisbee, CPC Lynn MA
Catheryn Instasi, CPC Middleboro MA
Anne Cunningham, CPC Millis MA
Laurie Ann Madelle, CPC Palmer MA
Carrie Goulet, CPC Southbridge MA
Gina Lawson, CPC Springfield MA

Erica Cooke, CPC Warwick MA
Hilary Ann Ferraro, CPC Watertown MA
Carol Spicer, CPC Whitman MA
Susan Kessler, CPC, CPC-P Baldwin MD
Gerin Hash, CPC Baltimore MD
Delphine McDowell-Dublin, CPC Bowie MD
Helen Seide, CPC Clarksburg MD
Darnell Ann Perez, CPC Elkridge MD
Candace S Williams, CPC Greenbelt MD
Diana Przybysz, CPC Laurel MD
Irina Reznikov, CPC Owings Mills MD
Sirisha Bommireddipali, CPC Rockville MD
Izetta Thomas, CPC Rockville MD
Marian Kispert, CPC Towson MD
Michelle Hafford, CPC Caribou ME
Joyce L Ellsmore, CPC Gorham ME
Pauline Doris McGuire, CPC Lewiston ME
Kimberly Reay Swift, CPC Litchfield ME
Santa Allaire, CPC No Berwick ME
Linda S Poirier, CPC Sabattus ME
Brenda Smock, CPC Allendale MI
Roxie Hawkins, CPC Canton MI
Rene M McAlister, CPC Center Line MI
Teresa Hacala, CPC Chesterfield Township MI
Kim Tharrett, CPC Clarkston MI
Amy Donegan, CPC East Lansing MI
Erin Sullivan, CPC East Lansing MI
Autumn Whitford, CPC East Tawas MI
Shannon Sadilek, CPC Flint MI
Wendy Loll, CPC Flushing MI
Kimberley S Eick, CPC Fort Gratiot MI
Cheryl Boezwinkle, CPC Grand Haven MI
Kasey Brown, CPC Grand Rapids MI
Cindy Hawley, CPC Grand Rapids MI
Lisa Kollin, CPC Grand Rapids MI
Toni Rysdyk, CPC Grand Rapids MI
Stephanie Lynn Shreve, CPC Grand Rapids MI
Sarah Winkler, CPC Grand Rapids MI
Brenda Brown, CPC Grass Lake MI
PJ Love, CPC Haslett MI
Katie Wells, CPC Holland MI
Catherine Kozlowski, CPC Howell MI
Ruth Haney, CPC Kalamazoo MI
Dana Elmore, CPC Lake City MI
Kathleen Ann Wilkie, CPC Lincoln Park MI
Rachel Hayes, CPC-H Lowell MI
Sandra Boyd, CPC Macomb MI
Erika Mitchell, CPC Millington MI
Mark A Crossley,CPC, CPC Petoskey MI
Christy Thurmes, CPC-H Pickford MI
Rebecca Leep, CPC Plainwell MI
Julie Sisk, CPC Plymouth MI
Kathleen J Wolfe, CPC Portage MI
Rebecca L Smith, CPC Royal Oak MI
Donna M Copeland, CPC Southfield MI
Natalie Kraydich, CPC Warren MI
Laurie Gougeon, CPC Waterford MI
Melissa Stansell, CPC Waterford MI
Debra Flaska, CPC West Bloomfield MI
Rita Ann Blodgett, CPC Wyoming MI
Cindy Barger, CPC Bethel MN
Marcia Miller, CPC Bloomington MN
Susan Quittum, CPC-P Coon Rapids MN
Ellen Bomstad, CPC Inver Grove Heights MN
Kristine D Dupree, CPC-H Maple Grove MN
TanaJean Brouillard, CPC Minneapolis MN
Debra Halvorson, CPC-H Minneapolis MN
Kerri Morris, CPC Minneapolis MN
Cathy J Stewart, CPC Prior Lake MN
Carolene Neumann, CPC Rochester MN
Heather Mairs, CPC S Moorhead MN
Amy Okke, CPC Savage MN
Janet Schweigert, CPC St Paul MN

Ilene Estabrook, CPC Warren MN
Michelle D Dietrich, CPC Canton MO
Sarah Nicole McDowell, CPC Cape Girardeau MO
Sonya Glastetter, CPC Chaffee MO
Tonia Marie Tobias, CPC Florissant MO
Cynthia Jackson, CPC Grandview MO
Linda Ball, CPC-H Independence MO
Stephanie Lynn Alewel, CPC Kansas City MO
Rebecca Cerro, CPC Kansas City MO
Rebecca Deanne Garcia, CPC Kansas City MO
Michelle Kylene Holt, CPC Kansas City MO
Shirley J Johnson, CPC Kansas City MO
Jeannie M Ruch, CPC Kansas City MO
David M Waldman, CPC Kansas City MO
Thomasine Honeycutt, CPC Liberty MO
Lacie Jean Kenney, CPC Parkville MO
Ann Winfrey, CPC Parkville MO
Savannah Bush, CPC Pleasant Hill MO
Melissa Meese, CPC, CPC Rogersville MO
Stan Gidley, CPC Smithville, MO MO
Jane Elizabeth Fox, CPC St Louis MO
Clare L Schilly, CPC Ste Genevieve MO
Barbara Sullentrup, CPC Washington MO
Michelle Stallings, CPC Willard MO
Keishala R Ashley, CPC Biloxi MS
Shayla Y Patton, CPC Florence MS
Lakisha Patrice Williams, CPC Jackson MS
Dorothy Dianne Blair, CPC Pearl MS
Tunja Johnson RN, MSN, CPC Winona MS
Tammy Engellant, CPC Billings MT
Deanna Stops, CPC, CPC-H, CPC-I Billings MT
Robin Diane Vukasin, CPC Great Falls MT
Mary Jane Hanify, CPC Helena MT
Blair Brown, CPC Albemarle NC
Leslie C Garrison, CPC Asheville NC
Jessica White, CPC Asheville NC
Anne Kirby, CPC Chapel Hill NC
Shannon Peck, CPC Charlotte NC
Deborah Ponder Kelley, CPC Concord NC
Stacey Miller, CPC Concord NC
Victoria Cardoze, CPC Durham NC
Arnold Coleman, CPC Durham NC
Erica Harris Smith, CPC Durham NC
Stephanie Halstead Cooper, CPC Elizabeth City NC
Kori C Bradley, CPC Gastonia NC
Kyna Robbins McKoy, CPC Gastonia NC
Ann Marie Lorenz, CPC Hampstead NC
Ingrid Korkkanen, CPC Harrisburg NC
Roseanne Sanders, CPC Huntersville NC
Janet Simmons, CPC Kannapolis NC
Cindy Stillwell, CPC Kannapolis NC
Cynthia Simpson, CPC-P Lewisville NC
Anne Ford, CPC Lumberton NC
Carol Hannon, CPC Matthews NC
Joseph Martin, CPC Matthews NC
LaDonna M Crowder, CPC Monroe NC
Janice Elaine Vance, CPC Morgantown NC
Lynn VerDow, CPC Oak Island NC
Pam A Manuel, CPC Pilot Mtn NC
Laura Azzi, CPC Raleigh NC
Lindsey Bryant, CPC Raleigh NC
Nicole Riley, CPC Raleigh NC
Betty Washburn, CPC Raleigh NC
Donna Jonkheer Ludlum, CPC Rocky Point NC
Nicki Mckee, CPC Southport NC
Janet Ratchford, CPC Stanley NC
Lea A Renegar, CPC Statesville NC
Janet Webb, CPC Tarboro NC
Ginger Caulder, CPC Trinity NC
Dee Payne, CPC Troutman NC

Susan Hodges, CPC Westfield NC
Dawn S Gurganus, CPC Wilmington NC
Terri Morrow, CPC Wilmington NC
Crystal MeAnn Parker, CPC Wilmington NC
Hunter Smith, CPC Wilson NC
Carolyn Grant, CPC Winston Salem NC
Linda Valnes, CPC-P West Fargo ND
Linda A Cole, CPC Lincoln NE
Julie Leu, CPC, CPMA, CPC-I Omaha NE
Lori L Nutter, CPC Omaha NE
Sumit Sharma, CPC Delhi New Delhi
Dheeraj Arora, CPC New Delhi New Delhi
Vijay Kumar, CPC New Delhi New Delhi
Myron Andrew Kuhre, CPC Cornish Flat NH
Mary Anne Rice, CPC Enfield NH
Renea Wright, CPC Avenel NJ
Andrea J Back, CPC Brick NJ
Danielle J Wombough, CPC-P Brick NJ
Meghan Berrigan, CPC Brown Mills NJ
Antoinette Smith, CPC Deptford NJ
Alecia Persley Carter, CPC Englewood NJ
Florence Hoch, CPC Ewing NJ
Darlene D Breen, CPC Green Brook NJ
Kelly Berge, CPC Haledon NJ
Katie A Lynn, CPC Hawthorne NJ
Parul Chandragiri, CPC Marlboro NJ
Roslyn Huger, CPC North Plainfield NJ
Nancy Sullivan, CPC North Plainfield NJ
Meg M Stagliano, CPC Ortley Beach NJ
Lynn S Rushfield, CPC Paramus NJ
Danielle Lin Whitehead, CPC Pennsville NJ
Charul Shah, CPC Princeton NJ
Nicole Zak, CPC Sayreville NJ
Rebecca Lynn Robinson, CPC Sparta NJ
Rosemarie Turner, CPC Spring Lake Heights NJ
Dana Schwartz, CPC Stratford NJ
Sandra Wittrien, CPC Wantage NJ
Karen C Ecker, CPC West Milford NJ
Danielle Ulshafer, CPC Wrightstown NJ
Joe Castro, CPC Albuquerque NM
Carol Ann Tooley, CPC Albuquerque NM
Amy Botello, CPC Roswell NM
Caprice D Walder, CPC Henderson NV
Carmen Dueñas, CPC Las Vegas NV
Amy Teramana, CPC Las Vegas NV
Sandy Steinhardt, CPC Laughlin NV
Pallas Buckley, CPC Zephyr Cove NV
Dorothy J Rowe, CPC, CPC-H Albany NY
Kristine J Knapik, CPC Altamont NY
Shamsul Islam, CPC Astoria NY
Jasmine Sanchez, CPC Beacon NY
Jennifer Borngraber, CPC Bowmansville NY
Yvonne Vazquez, CPC Bronx NY
Fredrick Campbell, CPC Brooklyn NY
Terri Y Collins, CPC Brooklyn NY
Rudolph Windsor Walford, CPC Brooklyn NY
Elizabeth Ann Freitag, CPC Cicero NY
Lisa Marie Adams, CPC Endicott NY
Jessica L Church, CPC Endicott NY
Kristin Marie Jenkins, CPC Endicott NY
Julie Anne Mackay, CPC Endicott NY
Susan M Jones, CPC Endwell NY
Ann M Ruby, CPC Endwell NY
Denise Burgos, CPC Fresh Meadows NY
Maureen F O'Toole, CPC Garnerville NY
Patti L Seneca, CPC Gowanda NY
Erin L Ryan, CPC Great Neck NY
Mary Koshy, CPC Hartsdale NY
Linda K Osborn, CPC Hastings On Hudson NY
Lisa Marie Vacchio, CPC Hicksville NY
Donna Marie Lusardi, CPC Kent Lakes NY
Nicole L Fredericks, CPC Little Falls NY
Jacqueline Hawver, CPC Marlboro NY

Shiela J Alessandrello, CPC, CPC-H Minoa NY
Margaret Hargrove, CPC Montgomery NY
Mandy L Brown, CPC Nassau NY
Florbela M Gomes, CPC New Rochelle NY
Shaun A Anderson, CPC New York NY
Karen M Belardo, CPC New York NY
Alectis Rezah M Peregrino, CPC New York NY
Monica Jovan Rosa, CPC New York NY
Mary Eleni Yeotsas, CPC New York NY
Francine Kaiser, CPC Niskayuna NY
Nancy L Grisanti, CPC, CPC-H Redwood NY
Amber L Smith, CPC Schenectady NY
Patricia Donegan, CPC Staten Island NY
Eileen Martino, CPC Staten Island NY
Kathleen Tansey, CPC Staten Island NY
Linda J Haley-Ross, CPC Syracuse NY
Jessica Lynn Redmond, CPC Syracuse NY
Kristin A Turan, CPC Syracuse NY
Margaret See, CPC Troy NY
Joel Michael Vandawalker, CPC Utica NY
Shalerie S Shene, CPC Vernon NY
Lynn Marie Neubauer, CPC Webster NY
Monica Y Blackshear, CPC Yonkers NY
Lindsay Marie Allen, CPC, CPC-H, CPC-P Akron OH
Lela Fishman, CPC Akron OH
Andrea Tournoux, CPC Alliance OH
Ellen D Windham, CPC Anna OH
Deborah Adams, CPC Ashland OH
Michele Brown-Craven, CPC Aurora OH
Maria Shinn Bouck, CPC Bay Village OH
Jane Becker, CPC Bolivar OH
Kimberly Zink, CPC Canal Fulton OH
Kathy Ann Flora, CPC Canton OH
Patricia Anne Rose, CPC Canton OH
Sarah Anne Schroeder, CPC Canton OH
Sara Shepherd, CPC Carrollton OH
Lynn Place, CPC Chagrin Falls OH
Leah Browning, CPC-H Chesapeake OH
Shari Pisseri, CPC Cincinnati OH
Melissa D Hibbard, CPC Clayton OH
Marilyn Jo Morningstar, CPC Danville OH
Holly A Mauric, CPC Dublin OH
Lori Spyridakis, CPC Eastlake OH
Jeanne-Anne Hillman, CPC Fairview Park OH
Wendy Wells, CPC Galion OH
Regina Ann Schlabach, CPC Hartville OH
Danielle Marie Whatling, CPC Hartville OH
Andrea Barthlow, CPC Lancaster OH
Klarissa Kuhn, CPC Lancaster OH
Brittney Padgett, CPC Lancaster OH
Jacqueline R Eubanks, CPC Louisville OH
Amber Cooney, CPC Loveland OH
Tianne Lunsford, CPC Mansfield OH
Ashley Marie Giaquinta, CPC Massillon OH
Tori Cordaro, CPC Mentor OH
Charlena Johnson, CPC New Richmond OH
Brenda K Poling, CPC Niles OH
Jennifer Clark, CPC North Canton OH
Ann Marie Hammond, CPC N. Canton OH
Brooklyn Diane Knapp, CPC N. Canton OH
Deborah Kay Rudish, CPC N. Canton OH
Cameo Myisha Davis, CPC Oakwood Village OH
Denise D Stefanowicz, CPC Parma OH
Alicia L Leonard, CPC Portage OH
Kimberly Ann Wiley, CPC Scio OH
Adriann Y Kennedy, CPC Shaker Hts OH
Christine Cybulski, CPC Sharonville OH
Madalyn Latricia Cargill, CPC-H Solon OH
Shannon Shields, CPC-H Toledo OH
Traci Davison, CPC-H Wellington OH
Tricia Marie Ruh, CPC West Chester OH

Sherri Evans, CPC Williamsburg OH
Lori Lynn Houston, CPC, CPC-H Bartlesville OK
Susan M Marshall, CPC, CPC-H Bartlesville OK
Jeanine Soard, CPC Broken Arrow OK
Barbara Brown, CPC Catoosa OK
Beth Orr, CPC Edmond OK
Deborah Dianna Scott, CPC Moore OK
Donna Delores Payne, CPC, CPC-H, CPC-P Morris OK
Timothy W Pesch, CPC Oklahoma City OK
Nyla Brown, CPC-P Tulsa OK
Debbie Lee, CPC Tulsa OK
Bryan Keith Lutherbeck, CPC-P Tulsa OK
Darla McFarland, CPC Tulsa OK
Beth-Ellen Hanson, CPC Albany OR
Jodi Lee Hacker, CPC Baker City OR
Jennifer Tappan, CPC Eugene OR
Gina Stevens, CPC Harrisburg OR
Jill Parker, CPC-H Lebanon OR
Spencer Bailey, CPC Portland OR
Amber L Carter, CPC Portland OR
Katie Loomis, CPC Portland OR
Naomi M Brazille, CPC, CPC-H Rogue River OR
Mary-Ann Young, CPC Salem OR
Heather Yunck, CPC Salem OR
Karol K Potter, CPC, CPC-P Springfield OR
Brian Smith, CPC Springfield OR
Jonnie Massey, CPC, CPC-P, CPMA, CPC-I Tigard OR
Kathleen Hennricks, CPC Veneta OR
Bridgette L Miles, CPC-H Chester PA
Kathryn Fasano, CPC East Stroudsburg PA
Shawna A Keller, CPC Elizabethtown PA
Jill Luce, CPC Hallstead PA
Bonita Berkhimer, CPC Harriburg PA
Anna Heidt, CPC, CIRCC Huntingdon Valley PA
Gwendolyn Sue Hawk, CPC, CPC-H Lititz PA
Alisha M Rohrer, CPC, CPC-H Lititz PA
Charlise N Hendrix, CPC Philadelphia PA
Cathy Hendrix-Wright, CPC Philadelphia PA
Donna Rall, CPC Pittsburgh PA
Linda Anne Lengle, CPC Reading PA
Lissette Roman, CPC Richboro PA
Elizabeth M Mason, CPC Warrington PA
Marianna Hegedus, CPC West Newton PA
Lilygold Calamba BonJoc, CPC, CPC-H, CPC-I Legazpi City PHI
Paula J Niedermann, CPC Charlestown RI
Tanya M Piermattei, CPC Charlestown RI
Patricia M Goddard, CPC Johnston RI
Margaret M Shay, CPC Lincoln RI
Sharon Scotto, CPC N Smithfield RI
Elizabeth M Lynch, CPC North Providence RI
Joan A Jones, CPC Portsmouth RI
Lisa M Nieves, CPC Providence RI
Rachel M McGuire, CPC West Warwick RI
Kimberly A Jones, CPC Westerly RI
Natalie Patrice Chamblee, CPC Anderson SC
Cindy Drews, CPC Charleston SC
Karmen Singleton, CPC Charleston SC
Amy Parnell Gamble, CPC Columbia SC
Deborah L Marthers, CPC Columbia SC
JoAnn C McQuillan, CPC Columbia SC
Sheila D Morris, CPC Columbia SC
Christine E Stewart, CPC Columbia SC
Terri Wilkins, CPC Dorchester SC
Carolyn Turner, CIRCC Fort Mill SC
Barbara Leigh Moyer, CPC Goose Creek SC
Angie Britcher, CPC Greenville SC
Tracy R Carbonel, CPC Greenville SC
Lynn K Parker, CPC Greenville SC
Stephanie Boyter Brown, CPC Inman SC
Deborah Carson, CPC Irmo SC

Nikki Meetze, CPC Irmo SC
Marilyn Mattice, CPC-H Isle Of Palms SC
Marcia Louise Young, CPC Leesville SC
Donna Bennett, CPC Mount Pleasant SC
Deanna Grant, CPC North Charleston SC
Katrina Dalerita Mitchem, CPC Spartanburg SC
Holly Marie Huizar, CPC Summerville SC
Kelly S Hewson, CPC West Columbia SC
Andrea Nicole Meyers, CPC Andersonville TN
Heather Pappas, CPC Brentwood TN
Kim Clowers, CPC Chattanooga TN
Donyalle Cornelius, CPC Chattanooga TN
Jamie S Johnston, CPC Chattanooga TN
Candice Dixon, CPC Cleveland TN
Linda A. Murley, CPC Collierville TN
Katherine Abel, CPC, CPMA, CPC-I Columbia TN
Carrie Ann Beuerlein, CPC Columbia TN
Angie Carol Marcum, CPC Dandridge TN
Kimberly Ann Mosier, CPC Harriman TN
Melanie H Henderson, CPC, CPC-H Hixson TN
Kay T Bell, CPC Knoxville TN
Marcie Danielle Sumner, CPC Knoxville TN
Kayla LeAnn Crews, CPC Lawrenceburg TN
Gina Morgan, CPC Lenoir City TN
Jennifer Pugh, CPC Monterey TN
Melissa R Colvett, CPC Mount Pleasant TN
Tonya Cobb, CPC Nashville TN
Samantha Waggoner, CPC Nashville TN
Jessica Whitten, CPC Nashville TN
Natalie Bachelor, CPC Powell TN
Jennifer Jeffers, CPC Rockwood TN
Susan Vradenburgh, CPC Signal Mountain TN
Sandra Marion, CPC Sneedville TN
Jeanene Jacobs, CPC Amarillo TX
Liz Jero, CPC Austin TX
Kim Rubin, CPC Austin TX
Alicia Marie Wackenreuter, CPC Beaumont TX
Myriam Nieves, CPC Boerne TX
Jennifer Arriola, CPC Canton TX
Brentt Hesse, CPC Carrollton TX
Sandra E Kunze, CPC, CPC-H, CPMA, CPC-I Castroville TX
Kimberly Kay Hampton, CPC Cleburne TX
Patricia Adkins, CPC, CPC-H Coppell TX
Gwen Reaves, CPC-H Coppell TX
Douglas Arrington, CPC-H Dallas TX
Sharla Yvonne Haynes, CPC Dallas TX
Melanie Hedgpeth, CPC Dallas TX
Darla Shirk, CPC Dallas TX
Tam Renee McBee, CPC Deer Park TX
Tammy Towers, CPC, CPC-H Desoto TX
Manuel Gutierrez, CPC El Paso TX
Boni Kelly, CPC Fort Worth TX
Jeanae Hernandez, CPC Garland TX
Alice L Janak, CPC Halletsville TX
Edith K Ballard, CPC, CPC-H Houston TX
Brigitte Gradney, CPC Houston TX
Violet LaKeisha Nelson, CPC Houston TX
Charlette Rasberry, CPC, CPC-H Houston TX
Marti J Geron, CPC, CPC-H Hurst TX
Michelle Stepp, CPC Hutto TX
Courtney Cofer, CPC Kyle TX
Misty Renee Walters, CPC La Porte TX
Olga Contreras, CPC Lubbock TX
Robin Pittman, CPC-H Midlothian TX
Beverly Hektner, CPC N. Richland Hills TX
Debra G Hindman, CPC, CPC-H Plano TX
Sophia Price, CPC Porter TX
Sherry Ellis, CPC Tyler TX
Lisa Gagliano, CPC Waxahachie TX
Sabrina Colleen Anzalone, CPC Clearfield UT
Debbie Currie, CPC Elk Ridge UT

Kat Durrant, CPC, CPC-H Layton UT
Kara Woods, CPC Lehi UT
Kristie Schostalo, CPC, CPC-H N. Logan UT
Dottie Carlson, CPC North Salt Lake UT
Luwain Proctor, CPC Orem UT
Sarah Barnhurst, CPC Pleasant Grove UT
Amy Debenham, CPC Pleasant Grove UT
Wendy Monson, CPC Pleasant Grove UT
Caroline Sapp, CPC Pleasant Grove UT
Amanda Wilson, CPC Pleasant Grove UT
Gail Kawamoto, CPC Sandy UT
ReNia Bingham, CPC, CPC-H Smithfield UT
Natalie E Colby, CPC South Salt Lake City UT
Shelly Bennett, CPC Spanish Fork UT
Gerarda Loeza, CPC Washington UT
Matt Fang, CPC West Jordan UT
Jennifer Hedegaard, CPC West Valley City UT
Charlet B Herr, CPC Alexandria VA
Robin Dale Powell, CPC Alexandria VA
Kathleen W Foster, CPC Catlett VA
Jan Johnson, CPC Chantilly VA
Nicole L Purvis, CPC Chesapeake VA
Tammy J Schilke, CPC Colonial Heights VA
Hanaa Samuel, CPC Fairfax VA
Tamara Ja'net Doss, CPC Fredericksburg VA
Nadjieh Oroumchi, CPC Great Falls VA
Susan E Jones, CPC, CPC-H Hampton VA
Carol Thomas, CPC Louisa VA
Gail Cole, CPC Mechanicsville VA
Caren J Swartz, CPC, CPC-H, CPMA, CPC-I Moseley VA
Ashley R Libbey, CPC Norfolk VA
MaryAnn W Tapia, CPC Norfolk VA
Cindy S Bailes, CPC Richmond VA
Elizabeth M Holmes, CPC Richmond VA
Jaci C Johnson, CPC, CPC-H, CPMA, CPC-I Richmond VA
Katherine Leigh Beghtol, CPC Stafford VA
Pamela Jean Spears, CPC Suffolk VA
Rebeka Sabet Khorrami, CPC Vienna VA
Tara K Van Eck, CPC Virginia Beach VA
Nera Kathleen Benton, CPC Woodbridge VA
Sara Noel Elliott, CPC Woodbridge VA
Evelyn Gantt, CPC Woodbridge VA
Katie Ann Howington, CPC Woodbridge VA
Allyson Martin, CPC Woodbridge VA
Nicole R LeBlanc, CPC, CPC-P Colchester VT
Karen Fondry, CPC-P East Montpelier VT
Claudia J Logan, CPC Essex Jct VT
Shawntel Jean Burke, CPC, CPC-P Milton VT
Derek D Nogle, CPC Arlington WA
Sam F Tyler, CPC Auburn WA
Carlos A Cruz, CPC Bellevue WA
Chantel Nilles, CPC Davenport WA
Linda Diane Jordin, CPC Everett WA
Theresa Renn, CPC Federal Way WA
Jeffrey Crank, CPC Gig Harbor WA
Cristine B Whitehurst, CPC Graham WA
James VanLeuven, CPC Kennewick WA
Vivek Murari, CPC Longview WA
Mary E Lehman, CPC Mountlake Terrace WA
Jane Perry, CPC Mountlake Terrace WA
Tamra Ruymann, CPC Olympia WA
Karin Vercamer, CPC Pullman WA
Terri Markovits, CPC Puyallup WA
Nancy Hill, CPC Shelton WA
Alice Kincaid, CPC Silverdale WA
Barbara Parker, CPC Silverdale WA
Holly D Willmering, CPC Spokane Valley WA
Jeffrey Sullivan Benavente, CPC Vancouver WA
Leslie Huck, CPC, CPC-P Vancouver WA
Kimberly A Messick, CPC Washougal WA
Sharon Rehfield, CPC Yakima WA
Melissa Lenzner, CPC Deerbrook WI
Carol Sue Daumer, CPC Fitchburg WI
Lisa S Baasch, CPC Marshfield WI
Nancy E McMahon, CPC Marshfield WI
Sylmonia Renee Jenkins, CPC Milwaukee WI
Michelle Elert, CPC-H Shorewood WI
Samantha German, CPC Spencer WI
Joy Rueckternwald, CPC Waukesha WI
Tifaney Rader, CPC Belle WV
Jamie Knox, CPC, CPC-P Charleston WV
Lori Ann Carey, CPC Clarksburg WV
Terry R Mace, CPC Cottageville WV
Bobbie Jo Mayer, CPC, CPC-H Fairmont WV
Gloria Jean Ferguson, CPC Huntington WV
Charla Dawn Keown, CPC Huntington WV
Kimberely Kay Graham, CPC, CPC-H Morgantown WV
Linda L Lingelbach, CPC Lusk WY
Jacqueline Gajewski, CPC Wausau WY

Apprentices

Jillian M Lee, CPC-A Anchorage AK
Mary Ann Jones, CPC-A Bessemer AL
Ebony M Bell, CPC-A Cowarts AL
Lynne Coker, CPC-A Enterprise AL
Charlene Scott, CPC-A Mobile AL
Rajesh Dhanalakota, CPC-A Secunderabad Andhra Pradesh
Apryle Trinity Herbert, CPC-A Fayetteville AR
Sydni Ava-LeAnne Jewett, CPC-A Fayetteville AR
Miranda Dianne Styles, CPC-A Fayetteville AR
James H Wonsower, CPC-A Fayetteville AR
Elizabeth Paige Thompson, CPC-A Lowell AR
Telisha Y Dickerson, CPC-A Malvern AR
Jeremy Dale Bridges, CPC-A Rogers AR
Rose Marie Hilton, CPC-A Apache Junction AZ
Christie Esau, CPC-A Avondale AZ
Patty Young, CPC-A Avondale AZ
Stacey Lynn Broucksou, CPC-A Cave Creek AZ
Hallie Jean Carrera, CPC-A Chandler AZ
Stephanie Walters, CPC-A Chandler AZ
Amy Fasulo, CPC-A Flagstaff AZ
Alexander Quintin Carpenter, CPC-A Gilbert AZ
Frances Cruz, CPC-A Gilbert AZ
Steven Robert Mobley, CPC-A Gilbert AZ
Ann Petersen, CPC-A Gilbert AZ
Julia A Pulliam, CPC-A Gilbert AZ
Jennifer Thomas, CPC-A Gilbert AZ
Kimberly A Zafiroff, CPC-A Gilbert AZ
Valerie Flowers, CPC-A Glendale AZ
Lisa Siciliano-Palmer, CPC-A Glendale AZ
Jennifer Gibson, CPC-A Golden Valley AZ
Diane Perry, CPC-A Golden Valley AZ
Lori Shrum, CPC-A Golden Valley AZ
Patricia Berumen, CPC-A Kingman AZ
Karen Ingroum, CPC-A Kingman AZ
Brenda North, CPC-A Kingman AZ
Cynthia Pierce, CPC-A Kingman AZ
Sarah Sexton, CPC-A Kingman AZ
Catherine Danielson, CPC-A Lake Havasu City AZ
Genevieve Wern, CPC-A Lake Havasu City AZ
Gail Chambers, CPC-A Mesa AZ
Mary Scott, CPC-A Mesa AZ
Katherine Marie Tsai, CPC-A Mesa AZ
Lee Conklin, CPC-A Oro Valley AZ
Donna M Gard, CPC-A Peoria AZ
Lisa Ivanoff, CPC-A Peoria AZ
Thomas C O'Gara, CPC-A Peoria AZ
Debra Brown, CPC-A Phoenix AZ
Shannon Davis, CPC-A Phoenix AZ
Sandi Renee Sandy, CPC-A Phoenix AZ
Lilydia T Ybanez, CPC-A Phoenix AZ
Terri Boylan, CPC-A Prescott AZ
Katie Sabo, CPC-A Prescott Valley AZ
Dhara Bakshi, CPC-A Sierra Vista AZ
Alex Braceland, CPC-A Tucson AZ
Nicolle Hage, CPC-A Tucson AZ
Cynthia L Kazda-Horvack, CPC-A Tuscon AZ
Josie Lindo, CPC-A Alhambra CA
Omar Velez, CPC-A Alhambra CA
Lori Okada, CPC-A Aliso Viejo CA
G. Gayle Hill, CPC-A Alpine CA
John Daley, CPC-A Antioch CA
Mary L Smith, CPC-A Antioch CA
Anasol L Shelledy, CPC-A Artesia CA
Lisa Asif-Beatty, CPC-A Bakersfield CA
Perry Martin Quesada, CPC-A Bay Point CA
Robin Thomas, CPC-A Beaumont CA
Griselda Covarrubias, CPC-A Bellflower CA
Valerie Jeanne Whalen, CPC-A Brea CA
Bernadette Carreon, CPC-A Buena Park CA
Alvianna Davis, CPC-P-A Camarillo CA
David Alcaraz, CPC-A Canoga Park CA
Mel Acebedo, CPC-A Cerritos CA
June Esquela, CPC-A Cerritos CA
Ellen Siegal, CPC-A Chatsworth CA
Margarita G Sablan, CPC-A Chula Vista CA
Angela Carpenter, CPC-A Citrus Heights CA
Ashley Fiset, CPC-A Concord CA
Amanda D O'Connor, CPC-A Concord CA
Mandy Mae Robison, CPC-A Costa Mesa CA
Katrina Etherington, CPC-A Cupertino CA
Junelyn R Image, CPC-A Daly City CA
Carole A Stallings, CPC-H-A Discovery Bay CA
Lilly Estrada, CPC-A Downey CA
Daisy Pelayo, CPC-A Downey CA
Patrice Christine Walrod, CPC-A El Cajon CA
Annette Rush, CPC-A Emeryville CA
Terri Rouse, CPC-A Fresno CA
Lisa Ojeda, CPC-A Fullerton CA
Eva Marie Granados, CPC-A Hacienda Heights CA
Meghan Mckee, CPC-A Huntington Beach CA
Cynthia Lagana, CPC-A Indio CA
Joseph Farias, CPC-A La Habra CA
Tamra Lynn Goins-Chott, CPC-A La Mesa CA
Lynda Bruns, CPC-A Lake Forest CA
Alan Castro, CPC-A Lakewood CA
Mcristle London, CPC-A Lakewood CA
Lacy Cole, CPC-A Lincoln CA
Deniz Ari, CPC-A Los Angeles CA
Angela L Belt, CPC-A Los Angeles CA
Pearl Sri Kanthi Boyd, CPC-H-A Los Angeles CA
Aribxa Franco, CPC-A Los Angeles CA
Dulce Soriano, CPC-A Los Angeles CA
Maria Carmencita Zara, CPC-A Los Angeles CA
Ludina Christina Martinus-Slad, CPC-A Martinez CA
Jami Hudson, CPC-A Mira Loma CA
Holly A Kallonen, CPC-A Murrieta CA
Scilla Piccini, CPC-A Norwalk CA
Tamiko Trott, CPC-A Norwalk CA
Caper Davis, CPC-A Novato CA
Hunter Thach, CPC-A Oakland CA
Velinda Kate Walton, CPC-A Oakley CA
Lori Acoba, CPC-A Ontario CA
Nirvi A Shah, CPC-A Palos Verdes Peninsula CA
Loretta Alkhatib, CPC-A Sacramento CA
Niela Jorvina Alvarez, CPC-A San Diego CA
Mary Jennifer Anaya, CPC-A San Diego CA
John Frederick Brindley, CPC-A San Diego CA
Barbara June Ford, CPC-A San Diego CA
Zina Lvovskiy, CPC-A San Diego CA
Theresa Marie Scherl, CPC-A San Diego CA
Cathy J Yarbrough, CPC-A San Diego CA
Michael Ciechon, CPC-A Santa Ana CA
Andy Abrams, CPC-A Torrance CA
Lilian Cativo, CPC-A Torrance CA
June Houng, CPC-A Torrance CA
Naomi Marie Wright, CPC-A Torrance CA
Li Zhang, CPC-A Torrance CA
Rafael Alexander Fernandez, CPC-A Tustin CA
Leslie K Oliver, CPC-A Westminster CA
Althea Roxas, CPC-A Whittier CA
Diana Griffin, CPC-A Arvada CO
Gail Reeves, CPC-A Arvada CO
Jennie R Alejandro, CPC-A Aurora CO
Roslyn Appelbaum, CPC-A Aurora CO
Kelly Boyer, CPC-A Aurora CO
Penny Esquibel, CPC-A Aurora CO
Jean Hamann, CPC-A Aurora CO
Natele M Humphries, CPC-A Aurora CO
Srilata Killamsetty, CPC-A Aurora CO
Sarah Lemaire, CPC-A Aurora CO
Rebekah M Loescher, CPC-A Aurora CO
Jeanne Schurr, CPC-A Bailey CO
Yan Jiang, CPC-A Centennial CO
Phyllis J Sigears, CPC-A Centennial CO
Teresa Eichinger, CPC-A Colorado Springs CO
Megan Doran, CPC-A Denver CO
Robin L Faliveno, CPC-A Denver CO
William Jamie Lujan, CPC-A Denver CO
Faye Elizabeth McGinnis, CPC-A Denver CO
Dawn Hudson, CPC-A Englewood CO
Samantha M Lipman, CPC-A Englewood CO
Debra Lea Bain, CPC-A Greeley CO
Daniel Caleb Hubbard, CPC-A Lafayette CO
Joan Kay Cockburn, CPC-A Littleton CO
Jennette Banigan, CPC-A Littleton CO
Carol Jean Graves, CPC-A Littleton CO
Mayme Kaiser, CPC-A Littleton CO
Whitney Horton, CPC-A Longmont CO
Jennifer Johnson, CPC-A Loveland CO
Elaine F Marston, CPC-A Northglenn CO
Kristin R Asis, CPC-A Bethany CT
Carol J Kacenski, CPC-A Branford CT
Patricia Morton, CPC-A Branford CT
Jessica Poon, CPC-A Branford CT
Elizabeth A Malysiak, CPC-A Bristol CT
Peggy Criscuolo, CPC-A Clinton CT
Kathy L Renda, CPC-A Danbury CT
Simmi Saxena, CPC-A Danbury CT
Maureen A Duffy, CPC-A, CPC-H-A Durham CT
MaryJane F Toomey, CPC-A East Haven CT
Cindy L Zimmerman, CPC-A Ellington CT
Lucyna Blach, CPC-A Enfield CT
Dana Anne Cinquanta, CPC-A Guilford CT
Margaret Radman, CPC-A Guilford CT
Alyssa D Buontempo, CPC-A Hamden CT
Alex Cielo, CPC-H-A Hartford CT
Lindsay Williams, CPC-A Manchester CT
Tracy Carlson-Ivers, CPC-A Mendon CT
Louise H Gurciullo, CPC-A Meriden CT
Raylene Pollock, CPC-A Meriden CT
Regina MacDonald-Kendall, CPC-A Milford CT
Lorna Ruth Parrish, CPC-A Milford CT
Susan Boyce, CPC-A Naugatuck CT
Mary Knockwood, CPC-A New Britain CT
Lorraine L Gauthier, CPC-A New Haven CT
Tiffany Miller, CPC-A New Haven CT
Lizzie Roulhac, CPC-A New Haven CT
Susan Ann Smith, CPC-A New London CT
Kerri Gadd, CPC-A North Haven CT
Deborah A Wood, CPC-A Plainville CT
Brianna Billot, CPC-A Rocky Hill CT
Ellen M Gannuscio, CPC-A, CPC-H-A Rocky Hill CT
Robin Hendrix, CPC-A Simsbury CT
Jennifer Fazzino, CPC-A Southington CT
Nancy M Gillis, CPC-A Taftville CT
Lamonica Steinman, CPC-A W. Haven CT
Catherine Cummins, CPC-A Westbrook CT
Vaishali Ghetia, CPC-A Windsor CT
Eric Stoecker, CPC-A Windsor Locks CT
Amber Guy, CPC-A Dover DE
Raelen B Knox, CPC-A Hockessin DE
Terri S Mingoia, CPC-A Newark DE
Stephanie Olin, CPC-A Newark DE
Sujatha Rajagopalan, CPC-A Wilmington DE
Susan Shuster, CPC-A Wilmington DE
Janet Cartee, CPC-A Arcadia FL
Deborah Larosa, CPC-A Bonita Springs FL
Kelly Steinmetz, CPC-A Bonita Springs FL
Louise Hatch, CPC-A Brooksville FL
Jacqueline Andrachak, CPC-A Cape Coral FL
Cathy Bedard, CPC-A Cape Coral FL
Shannon Hartline, CPC-A Cape Coral FL
Deborah Peters, CPC-A Cape Coral FL
Jeff Rodriguez, CPC-A Cape Coral FL
Peta Sloan, CPC-A Cape Coral FL
Suzanne Smith, CPC-A Cape Coral FL
Lucy Trupo, CPC-A Cape Coral FL
Jamie Millender, CPC-A Carrabelle FL
Stephanie Ayres, CPC-A Clearwater FL
Parker McKnight, CPC-A Clearwater FL
Erin Nigro, CPC-A Clearwater FL
Jean I Thomas, CPC-A Clearwater FL
Bey Xiong, CPC-A Clearwater FL
Heather Kay Harrison, CPC-A Dunedin FL
Svetlana Martin, CPC-A Dunedin FL
Fang Yang, CPC-A Ellenton FL
Andrea Willis, CPC-A Florida City FL
Dean Blackwelder, CPC-H-A Fort Lauderdale FL
Marianne Parker, CPC-A Fort Myers FL
Mark Schoonmaker, CPC-A Fort Myers FL
Stanley Wilson, CPC-A Fort Myers FL
Angela Mabry-Reese, CPC-A Ft Pierce FL
Carol Jeanne Reese, CPC-A Ft Pierce FL
Elizabeth White, CPC-A Gainesville FL
Lori M Bittner, CPC-A Grant FL
Amy Mcknight, CPC-A Havana FL
Karen Cohoon, CPC-H-A Hernando FL
Richard Bernhardt, CPC-A Homestead FL
Nancy Robertson, CPC-A Hudson FL
Monica Berg, CPC-A Jacksonville FL
Becky Rewis, CPC-A Jacksonville FL
Roberta Slinger, CPC-A Jacksonville FL
Molly Bunshaft, CPC-A Jupiter FL
Paola Estrada, CPC-A Land O Lakes FL
Richard Canner, CPC-A Largo FL
Cary Greenberg, CPC-A Largo FL
Tamara Laubhan, CPC-A Largo FL
D Joanne Renaud, CPC-A Largo FL
Adele Hunter, CPC-A Lehigh Acres FL
Katie L Yetman, CPC-A Melbourne FL
Dawn Pruitt, CPC-A Mexico Beach FL
Roger Lopez Del Castillo, CPC-A Miami FL
Mary Ward, CPC-A Miami FL
Jenny Marlene Castillo, CPC-A Miami Lakes FL
Jennifer Kane, CPC-A Naples FL
Karen Mancuso, CPC-A Naples FL
Alena Sager, CPC-A Naples FL
Jeanne F Smith, CPC-A Navarre FL
Donna M Vandermeide, CPC-A Navarre FL
Terry Sue Gunter, CPC-A New Port Richey FL
Judy Kintner, CPC-A New Port Richey FL
Carol Tarumi Anderson, CPC-A Orange Park FL
Paula Buckingham, CPC-A Orange Park FL
Cindy Holland, CPC-A Pace FL
Luann Steely, CPC-A Palatka FL
Lindsey Jean Blair, CPC-A Palm Bay FL
Kerry Faber, CPC-A Palm City FL
Angela Hart, CPC-A Palm City FL
Maritzabel Garcia, CPC-A Pembroke Pines FL
Rebecca E Hammett, CPC-A Pensacola FL
Linda Gramlick, CPC-A Pinellas Park FL
Julie Harrell, CPC-A Pinellas Park FL
Lorena Carrizo, CPC-A Plant City FL
Jennifer Lumpkin, CPC-A Port Richey FL
Darcey Rice, CPC-A Saint Petersburg FL
Cynthia Bass, CPC-A Sarasota FL
Robin Moynihan, CPC-A Sarasota FL
Pamala J Wolf, CPC-A Sebastian FL
Elizabeth Aughinbaugh, CPC-A Seminole FL
Colleen Boylan, CPC-A Seminole FL
Debra L Adkins, CPC-A Spring Hill FL
Mark Holley, CPC-A Spring Hill FL
Diane Ortiz, CPC-A Spring Hill FL
Cheryl Paradis, CPC-A St Pete Beach FL
Marylou G Muha, CPC-A St Petersburg FL
Shannon Singer, CPC-A St Petersburg FL
Eric Sloss, CPC-A St Petersburg FL
Swati Desai, CPC-A Tampa FL
Revat Lakhia, CPC-A Tampa FL
Dipa Maradia, CPC-A Tampa FL
Pragneshkumar Patel, CPC-A Tampa FL
Diana Jean Galloway, CPC-A Titusville FL
Laura L Fiaccavento, CPC-A Vero Beach FL
Kimberly Graham, CPC-A Vero Beach FL
Alice C Harrison, CPC-A Vero Beach FL
Judith Ann Jensen, CPC-A Vero Beach FL
Brenda G Montgomery, CPC-A Vero Beach FL
Kathmia LaCheryl Strachan, CPC-A Vero Beach FL
Emily Joyce Teague, CPC-A Vero Beach FL
Robin Cunnings, CPC-A West Palm Beach FL
Louise A Mathews, CPC-A Weston FL
Magda Axt, CPC-A Alpharetta GA
Meredith Wilson, CPC-A Americus GA
Alison Schmitz, CPC-A Atlanta GA
Cedric Whitfield, CPC-A Atlanta GA
Kathryn Zaitz, CPC-A Atlanta GA
Princess N Childs, CPC-A Augusta GA
Joyce Gibbs, CPC-A Augusta GA
Robert Gorham, CPC-H-A Austell GA
Revonda Jones, CPC-A Conyers GA
Leslie Dawn Scharnhorst, CPC-H-A Cumming GA
Brenda Lezzette Williams, CPC-H-A Decatur GA
Debbie P Long, CPC-A Duluth GA
Dorel Radivoj, CPC-A Duluth GA
Mallory Antonacci, CPC-A Evans GA
Kelli Johnson, CPC-A Fairburn GA
Kyla Mencey Tomlin, CPC-A Fairburn GA
Rhonda Sharon Brumbalow, CPC-A Gainesville GA
Tomitra Spiller, CPC-A Grovetown GA
Jonathan Coronel, CPC-A Hephzibah GA
Vicki Foster, CPC-A Hephzibah GA
Shujuan N Kelly, CPC-A Kennesaw GA
Pamela Noakes, CPC-A Kennesaw GA
Karen Thornburgh, CPC-A Kennesaw GA
Carly Danielle Chapman, CPC-A Lawrenceville GA
Dosia Irene Donald, CPC-A Lawrenceville GA
Ashley Blessett, CPC-H-A Lithonia GA
Jennifer Mizerak, CPC-A Marietta GA
Melanie Spain, CPC-A Marietta GA

Dana Conley, CPC-A Newnan GA
Kim Geiss, CPC-A Peachtree City GA
Candace K Kraus, CPC-A Savannah GA
Gloria Mcmillon, CPC-A Stockbridge GA
Dawn Long, CPC-A Suwanee GA
Jill Bledsoe, CPC-A Woodstock GA
Kim Trotta, CPC-A Woodstock GA
Ashley Agpaoa, CPC-A Ewa Beach HI
Lari Anne Kamei, CPC-A Honolulu HI
Jana Miller, CPC-A Ankeny IA
Amelia J Cox, CPC-A Council Bluffs IA
Natalie Lamp, CPC-H-A Council Bluffs IA
Christina D Osborne, CPC-A Council Bluffs IA
Lynne A Reed, CPC-A Des Moines IA
Lynn Sherwood, CPC-A Des Moines IA
Christine Mckibben, CPC-A Waukee IA
Amber Andrews, CPC-A Boise ID
Cathy Grako, CPC-A Meridian ID
Nancy Owens, CPC-A Meridian ID
Cheryl Reed, CPC-A Meridian ID
Johanna Kratt, CPC-A Star ID
Sarah Jane Eveland, CPC-A Apple River IL
Luellyn Cherry, CPC-A Arcola IL
Dawn Stafford, CPC-A Bartonville IL
Shanda Michelle Strawkas, CPC-A Buffalo IL
Theresa Brewis, CPC-A Cary IL
Jamie Bybee, CPC-A Cary IL
Julie Scott, CPC-A Cary IL
Vanessa Alison Flanagan, CPC-A Chicago IL
Trina M Jackson, CPC-A Chicago IL
Laura Kubitz, CPC-A Chicago IL
Anette Martinez, CPC-A Chicago IL
Oriana Pero, CPC-A Chicago IL
Beth Rudat Devaney, CPC-A Crystal Lake IL
Julie Ann Rugh, CPC-A Dixon IL
Jessica Lynn Joniak, CPC-A Dupo IL
Joanna Tkacz, CPC-A Fox River Grove IL
Amber Rose Gill, CPC-A Freeport IL
Pamela Masek, CPC-H-A Glen Ellyn IL
Rene Hartman, CPC-A Granite City IL
Yvette Hinton, CPC-A Granite City IL
Sarah Millburg, CPC-A Greenfield IL
Sarah Johnson, CPC-A Harvard IL
Nancy S Hendrix, CPC-A Hindsboro IL
Amanda Kay Whitley, CPC-A Humboldt IL
Michele Kloet, CPC-A Joliet IL
Michelle Valentino, CPC-A Lansing IL
Karen Lynne Smith, CPC-A Mattoon IL
Melissa Russo, CPC-A Monee IL
Sherry Sroka, CPC-A Monee IL
Tiffany Briggs, CPC-A Montgomery IL
Marlena A. Kerr, CPC-A Mt Carroll IL
Jennifer Lynn Posewick, CPC-A New Lenox IL
Joan Lynn Spangler, CPC-A New Lenox IL
Pauline F Kearney, CPC-A Oak Lawn IL
Laura Lee Roberts, CPC-A Palmyra IL
Jennifer L Graddick, CPC-A Park Forest IL
Jessica Lynn Evans, CPC-A Peoria IL
Danielle N Gordon, CPC-A Peoria IL
Kristie Michelle Klinedinst, CPC-A Peoria IL
Denise Mrozek, CPC-A Pontiac IL
Vickie Carpenter, CPC-A Pontoon Beach IL
Linda Krebel, CPC-A Red Bud IL
Mikaela Goza, CPC-A Rockford IL
Julie Ann Brigham, CPC-A Savanna IL
Janeen Melton, CPC-A Sesser IL
Melissa Renee Dodson, CPC-A Springfield IL
Susan Mary Robert, CPC-A Springfield IL
Deborah Kay Warden, CPC-A Springfield IL
Stacey Evelyn Dravis, CPC-A Sterling IL
Sandra Sheahan, CPC-A Union IL
Mary Kurka, CPC-A Woodstock IL
Tammy Sankey, CPC-A Woodstock IL
Casey Sullivan, CPC-A Woodstock IL
Romelia Desiderio, CPC-A Crown Point IN
Amanda Phillips, CPC-A Elkhart IN
Kathleen Kuntz, CPC-A Fishers IN
Joan Denise Wilberg, CPC-A Fishers IN
Jennifer Dixon, CPC-A, CPC-H-A Fort Wayne IN
Steven Edward McAdams, CPC-A Franklin IN
Christine Jones, CPC-A Granger IN
Denise Walczewski, CPC-A Granger IN
Julie Davis, CPC-A Indianapolis IN
Sharon Flittner, CPC-A Indianapolis IN
Kathy Henderson, CPC-A Indianapolis IN
Jody Marie Casey, CPC-H-A Jeffersonville IN
Miranda Jo Hall, CPC-A Lexington IN
Sametha LaVette Cunningham, CPC-A, CPC-H-A New Albany IN
Tracy Marie White, CPC-A Noblesville IN
Laura Fudacz, CPC-A Schererville IN
Felicity Watson, CPC-A Seymour IN
Brock Berta, CPC-A South Bend IN
Michelle Lynn Philipp, CPC-A St John IN
Leslie Storckman, CPC-A Tell City IN
Karen Marie Kugler, CPC-A Wolcott IN
Doyle Baker, CPC-A Colby KS
Jennifer Sue Bergeron, CPC-A De Soto KS
Linda Hightower, CPC-A Derby KS
Jenni Donnelly, CPC-A Olathe KS
Jeannie Harris, CPC-A Olathe KS
Wendy Richey, CPC-A Park City KS
Janice L Doherty, CPC-A Shawnee KS
Kristen Renee Foster, CPC-A Topeka KS
Jacqueline Keddie-Holt, CPC-A Topeka KS
Tammie Schooler, CPC-A Topeka KS
Sheena Marie Dixon, CPC-A Wichita KS
Meghan Rebecca Forsythe, CPC-A Wichita KS
Colleen K Graber, CPC-A Wichita KS
Crystal Main, CPC-A Wichita KS
Crystal L Rooker, CPC-A Campbellsville KY
LaVonda Renne Luke, CPC-A Covington KY
Shannon Renee Rice, CPC-A, CPC-H-A Coxs Creek KY
Catherine Carrier, CPC-A Crab Orchard KY
Cari-Lynn Horn, CPC-A, CPC-H-A Crestwood KY
Sheila H Weihe, CPC-A, CPC-H-A Crestwood KY
Barbara Crawford, CPC-A Danville KY
Coleen Edwards, CPC-A Fairdale KY
Robyn Gail Bomba, CPC-A Franklin KY
Rebecca A Webber, CPC-A Georgetown KY
Jo Ann Williams, CPC-A Georgetown KY
Lisa Ann Hanner-Black, CPC-A Glasgow KY
Janna Webb, CPC-H-A Greensburg KY
Angela Ziegler, CPC-A Hebron KY
Kelley L Hoff, CPC-A, CPC-H-A La Grange KY
Debbie Ann Michum, CPC-A, CPC-H-A La Grange KY
Kathleen L Boggs, CPC-A Lexington KY
Natalie Bush, CPC-A Lexington KY
Jessica E Cook, CPC-A Lexington KY
Valerie Dawson, CPC-A Lexington KY
Shebonnia C Griffith, CPC-A Lexington KY
Lynette Sue Gurney, CPC-A Lexington KY
Cheryl Lee Humphreys, CPC-A Lexington KY
Tara Elaine McNary, CPC-A Lexington KY
Debra Lynn Moore, CPC-A Lexington KY
Rachael Paulus, CPC-A Lexington KY
Rachelle Powers, CPC-A Lexington KY
Jennifer Thompson, CPC-A Lexington KY
Melissa Nicole VanHoose, CPC-A Lexington KY
Constance Ward, CPC-A Lexington KY
Bonitta Lynn Zewicke, CPC-A Lexington KY
Shimika Shanee Ashby, CPC-A Louisville KY
Rebecca Sue Basham, CPC-A, CPC-H-A Louisville KY
Maja M Drane, CPC-H-A Louisville KY
Kaysi Gaddis, CPC-A Louisville KY
Shannon R Griffiths, CPC-A Louisville KY
Tiffany A Hutchens, CPC-A, CPC-H-A Louisville KY
Amber Christine Legler, CPC-A Louisville KY
Shannon Marie Miller, CPC-A, CPC-H-A Louisville KY
Karrie Montague, CPC-A Louisville KY
Davida Yvonne Nathan, CPC-H-A Louisville KY
Odettys Oramas, CPC-A Louisville KY
Denise Darlene Phegley, CPC-H-A Louisville KY
Tiffany Monet Vaughn, CPC-A, CPC-H-A Louisville KY
Kathy Wheatley, CPC-A Louisville KY
Faye Stumbo, CPC-A Mc Dowell KY
Deborah Dawn King, CPC-A Midway KY
Brittany Frye, CPC-A Mt Washington KY
Hope Ann Wilson, CPC-A Nicholosville KY
Amy Ely, CPC-A Perryville KY
Karen Wethington, CPC-A Perryville KY
Tanya Renee King, CPC-A, CPC-H-A Shelbyville KY
Tiffany Sue Massie, CPC-A Taylor Mill KY
Rebecca N Keeney, CPC-A Waco KY
Shasta Nash, CPC-A Whitesville KY
Xochi K Colbert, CPC-A Wichita KY
Brittany Nicole Duelm, CPC-A Bosner City LA
Christine Rauber, CPC-A Hammond LA
Kahala Marie Latson, CPC-A Shreveport LA
Stacy Lauren Lawson, CPC-A Shreveport LA
Margot Metoyer, CPC-A Shreveport LA
Jasmine Monique Rachal, CPC-A Shreveport LA
Jackquinette Michelle Randell, CPC-A Shreveport LA
Stephanie Page Smith, CPC-A Shreveport LA
Eva Margaretha Zachary, CPC-A Walker LA
Anne Mcmonagle, CPC-A Andover MA
Shellie Roney, CPC-A Cambridge MA
Christine Zavala, CPC-A Charlestown MA
Scott Anthony Sylvia, CPC-A Dartmouth MA
Kathleen Mularski, CPC-A Easthampton MA
Kimberly Stone, CPC-A Holden MA
Robyn Mary Rouleau, CPC-A Littleton MA
Kim Franklin, CPC-A Lowell MA
Nancy Dion, CPC-A Mansfield MA
Kelly L Fitzgerald, CPC-A Methuen MA
Jamie Ryan, CPC-A Raynham MA
Laurie Parker, CPC-A Scituate MA
Hafida Maskoute, CPC-A Somerville MA
Ashley Chanel Harris, CPC-A Southaven MA
Deborah Boudreau, CPC-A Springfield MA
Jennilee Pacheco, CPC-A Springfield MA
Tamar Demerjian, CPC-A Watertown MA
Naomi Hyun, CPC-A Watertown MA
Archana Dadaji Ahire, CPC-A Nasik Maharashtra
Pallavi Prakash Badhan, CPC-A Nasik Maharashtra
Charusheela Deepak Bhati, CPC-A Nasik Maharashtra
Manisha Vijay Tungar, CPC-A Nasik Maharashtra
Suvarna Bhaskar Ugale, CPC-A Nasik Maharashtra
Jennifer Smith, CPC-A Annapolis MD
Theresa Bond, CPC-A Baltimore MD
Diana Dalto, CPC-A Baltimore MD
Audrey Oney, CPC-A Baltimore MD
Candice M Kessler, CPC-A Brooklyn MD
Kathleen Schoen Markovs, CPC-A Brookville MD
Susan Sean Smith, CPC-A Crofton MD
Agnes Apea, CPC-A Ijamsville MD
Susan A Streckfus, CPC-A Joppa MD
Mwikali Mutia, CPC-A Landover MD
Catherine M Greer, CPC-A Pasadena MD
Miriam Clark, CPC-A Randallstown MD
Debbie Bloom, CPC-A Westminster MD
Kathy McDonald, CPC-A Eliot ME
Gina Dicrocco, CPC-A Farmington ME
Melanie Miller, CPC-A Lamoine ME
Debra A Richardson, CPC-A New Gloucester ME
Rae M Thompson, CPC-A Saco ME
Sarah O'Brien, CPC-A Sanford ME
Susan Jennifer Woodbury, CPC-A South Becwick ME
Patti G Davignon, CPC-A Wiscasset ME
Nancy S Cinciarelli, CPC-A Allen Park MI
Katelyn Weese, CPC-A Ann Arbor MI
Mary Ann O'Connor, CPC-A Capac MI
Claudia Olejniczak, CPC-A Clarkston MI
Jennifer Geml, CPC-A Clinton Township MI
Patricia Okerhjelm, CPC-A Clinton Township MI
Wilma Rayshenia Woods, CPC-A Comstock Park MI
Shawna Hale, CPC-A Davison MI
Marilyn Greathouse, CPC-A Dimondale MI
Kelly Levandoski, CPC-A Dorr MI
Amy Louise Bashore, CPC-A East Lansing MI
Kimberly Dawn Lokken, CPC-A Flushing MI
Margaret Ray, CPC-A Garden City MI
MariJo Irene Bakale, CPC-A Grand Haven MI
Jill Hodges, CPC-A Grand Ledge MI
Belann Bennett, CPC-A Grand Rapids MI
Karen Pierantoni, CPC-A Grosse Pointe Woods MI
Roberta Luther, CPC-A Highland MI
Sandra Ann Gort, CPC-A Jenison MI
Diane Modica, CPC-A Lake Orion MI
Sandra Elbe, CPC-A Lincoln Park MI
Maria Elena Kucinski, CPC-A Livonia MI
Mary Matt, CPC-A Macomb MI
Kathleen Mckenna, CPC-A Northville MI
Stephanie Prior, CPC-A Okemos MI
Lynn Ann Skippen, CPC-A Okemos MI
Antoinette A Talovich, CPC-A Ortonville MI
Margaret Shimsky-Patterson, CPC-A Plymouth MI
Renee Mcknight, CPC-A Redford MI
Mary Taylor, CPC-A Riverview MI
Mindy Edwards, CPC-A Roseville MI
Jean Mcquade, CPC-A Roseville MI
Karen Kaufman, CPC-A St Clair Shores MI
Michelle Yum, CPC-A St Clair Shores MI
Arjun Barigela, CPC-A Sterling Heights MI
Cassandra Hamiel, CPC-A Sterling Heights MI
Kimberly Manick, CPC-A Westland MI
Michele Brock, CPC-A Wyoming MI
Corinne Ann Wurst, CPC-A Apple Valley MN
Gwen McDermeit, CPC-A Bloomington MN
Colleen Sackrider, CPC-A Brooklyn Park MN
Jocelyn Hintze, CPC-A Chaska MN
Susan Adams, CPC-P-A Coon Rapids MN
Barbara Das, CPC-A Eden Prairie MN
Claire Huisman, CPC-A Ely MN
Robin Mccullough, CPC-A Faribault MN
Jennifer Louise Hartzell, CPC-A Inver Grove Heights MN
Allyson Ashley, CPC-A Minneapolis MN
Catherine Young, CPC-A North Mankato MN
Beth Evans, CPC-A Owatonna MN
Kristina Dahle, CPC-A Thief River Falls MN
Jessica Wilhelm, CPC-A Arnold MO
Connie Fager, CPC-A Belton MO
Ronica Venegas, CPC-A Blue Springs MO
James O'Rourke, CPC-A Boonville MO
Deborah Jean Abrutz, CPC-A Cameron MO
Daniel Arvel Froemling, CPC-A Cape Girardeau MO
Eric John Knudtson, CPC-A Chesterfield MO
Rene Blagg, CPC-A Columbia MO
Jodi Matkosky, CPC-A Freeman MO
Greg Mitchell, CPC-A Hillsboro MO
On Wing Wong, CPC-A Independence MO
Beverly Sue Conner, CPC-A Jefferson City MO
Erica Renee' Roberson, CPC-A Jennings MO
Krystal Cantrell, CPC-A Kansas City MO
Terri Coburn, CPC-A Kansas City MO
Leigh Ann Howe, CPC-A Latham MO
Judith Anne Cooper, CPC-A Manchester MO
Nicole Dianne Dickens, CPC-A Pevely MO
Donelle Smith, CPC-A Platte City MO
Brianna Nicole Bealer, CPC-A St Louis MO
Amy Carroll, CPC-A St Louis MO
Kathy Cochran, CPC-A St Louis MO
Alicia Marlane Dowdle, CPC-A St Louis MO
Amanda S Martin, CPC-A St Louis MO
Joan Sidiropoulos, CPC-A St Louis MO
Ashley Lynn Sluka, CPC-A St Louis MO
Libby Ullo, CPC-A St Louis MO
Christine Bartner, CPC-A St Peters MO
Amber Ballew, CPC-A Trimble MO
Gloria Davis, CPC-A Weston MO
Ana Louise Middleton, CPC-A Jackson MS
Yevgenia Wilkerson, CPC-A Jackson MS
Amy Lynn Fowler, CPC-A Pearlington MS
Vikki Goodman, CPC-H-A Pelahatchie MS
Tenille Bomar, CPC-A Billings MT
Andrew Egge, CPC-A Billings MT
Desirae Hope Johnson, CPC-A Billings MT
Deborah K Wiesner, CPC-A Billings MT
Jennifer Gale, CPC-A Aberdeen NC
Kimberly Hart, CPC-A Advance NC
Jenny Fitzpatrick, CPC-A Arden NC
Alicia Sutton, CPC-A Burlington NC
Stephanie Thompson, CPC-A Burlington NC
Amy Lynn Kermitz, CPC-A Camden NC
Michelle Lynn McCrary, CPC-A Catawba NC
Mary Mak, CPC-A Chapel Hill NC
Karin R Carr, CPC-A Charlotte NC
Terri Joyce Crawford, CPC-A Charlotte NC
Paulette Hinton, CPC-A Charlotte NC
Thomas R Hoctor, CPC-A Charlotte NC
Heather Kreider, CPC-A Charlotte NC
Hannah M Lewis, CPC-A Charlotte NC
Carla Marques, CPC-A Charlotte NC
Josephine Ogbonna, CPC-A Charlotte NC
Catherine Jean Puett, CPC-A Charlotte NC
Susan Rehley, CPC-A Charlotte NC
Antonia Wilson, CPC-A Charlotte NC
Susan Nichole White-Fisher, CPC-A Cherryville NC
Beth Cruse, CPC-A Concord NC
Ashley Brooke Oakley, CPC-A Creedmoor NC
Lori Ann Fenner, CPC-A Durham NC
Anne Tempest, CPC-A Durham NC
Sheryl Williams McAdams, CPC-A Elon NC
Rachel Allen, CPC-A Graham NC
Sandra White, CPC-A Graham NC
April W LeClear, CPC-A Harrisburg NC
Jill Johnson, CPC-A Hendersonville NC
Ellen Helper Stone, CPC-A Indian Trail NC
Dana Jasper, CPC-A Jacksonville NC
Deborah Walling, CPC-A Lenoir NC
Cynthia Martin, CPC-A Locust NC
Lisa Combs, CPC-A Matthews NC
Lauren Griffin, CPC-A Matthews NC
Cheryl Anne Johnston, CPC-A Matthews NC
Myra Ringl, CPC-A Matthews NC
Lynn Bodine, CPC-A Mebane NC
Betty Bush, CPC-A Mebane NC
Alicia Spaulding, CPC-A Mebane NC
Renee Dickens, CPC-A Monroe NC
Jeffrey Franz, CPC-A Mooresville NC
Nancy Rogers, CPC-A Mooresville NC
Marianne M Todd, CPC-A Mount Gilzad NC
Sharon Huggins, CPC-A Mt Holly NC
Toni Coffman, CPC-A Raeford NC
Gayle Gentry Ferguson, CPC-A Reidsville NC
Melissa Martin, CPC-A Snow Camp NC
Teressa Way, CPC-A Snow Camp NC
Molly Bizzell, CPC-A Southern Pines NC
Roxanne Moses, CPC-A Statesville NC
Lynda Delena, CPC-A Waxhaw NC
Joyce Clements, CPC-A Weaverville NC
Veronique Anne-Marie Langlois, CPC-A Wilmington NC
Troy Antonio Short, CPC-A Winterville NC
Michelle Pritchett, CPC-A Bellevue NE
Michelle Weigel, CPC-A Randolph NE
Charli Dionne Meinberg, CPC-A Seward NE
Kathryn Ayres Olson, CPC-A Barrngton NH
Lorie Alibrio, CPC-A Bedford NH
Susan J Metts, CPC-A Derry NH
Heather B Blunt, CPC-A Grantham NH
Lynn A Langley, CPC-A Lebanon NH
Pamela Easton Langlois, CPC-A Lebanon NH
Stephanie Broussard, CPC-A Litchfield NH
Michele Hannon, CPC-A Littleton NH
Jamie Mosefski, CPC-A Milford NH
Bernadette Zakiewicz, CPC-A Milton NH
Melanie J Hamilton, CPC-A Newport NH
Lynn E Lynch, CPC-A Newport NH
Paula Callanan, CPC-A Portsmouth NH
Kristin Anne Stone, CPC-A Rochester NH
Tracy Watts, CPC-A Rochester NH
Jennifer Lessard, CPC-A Salem NH
Michele Leigh Zani, CPC-A Salem NH
Regina McGee, CPC-A Bloomfield NJ
Raisa Yelena G Valerio, CPC-A Bloomfield NJ
Linda Rose Sirks, CPC-A Bricks NJ
Julie E Bogutz, CPC-A Cherry Hill NJ
Adriene Pasmanick, CPC-A Cherry Hill NJ
Elizabeth Painter, CPC-A Clifton NJ
Elizabeth Zamorski, CPC-A Cranford NJ
Michelle Rhyme, CPC-A Deptford NJ
Patricia J Monteverde, CPC-A Elizabeth NJ
Lorain A Huang, CPC-A Farmingdale NJ
Serita Rose Giordano, CPC-A Haddonfield NJ
Cynthia Alfaro, CPC-A Howell NJ
Laurie Cooper, CPC-A Howell NJ
Kent Davenport, CPC-A Howell NJ
Karen A Meredith, CPC-A Lavallette NJ
Barbara Dolan, CPC-A Little Egg Harbor NJ
Cynthia Baur, CPC-A Manahawkin NJ
Kimberly Chadziutko, CPC-A Manalapan NJ
Virginia Nordgaard, CPC-A Middletown NJ
Sreelakshmi Pandurangan, CPC-A Monmouth Junction NJ
Shari Tucker, CPC-A Monroe Township NJ
Catherine Diane Visconti, CPC-A

Monroeville NJ
Kara Butala, CPC-A Neptune NJ
Nancy Goldman, CPC-A Rumson NJ
Donna Dolan, CPC-H-A Toms River NJ
Priti Kumar, CPC-A Toms River NJ
Robert S Brannon, CPC-A Albuquerque NM
Valerie Crawford, CPC-A Albuquerque NM
Doreen Ogard, CPC-A Albuquerque NM
Bernadette Pacheco, CPC-A Albuquerque NM
Michael Scott Walker, CPC-A Albuquerque NM
Diane Garcia, CPC-A Rio Rancho NM
Patricia Sue Westfall, CPC-A Roswell NM
Kristie Renae Vaca, CPC-A Henderson NV
Shonna Bayer, CPC-A Las Vegas NV
Justin R Spencer, CPC-A Angola NY
Joan A Burnett, CPC-A Bainbridge NY
Michele C Coughlin, CPC-A Baldwinsville NY
Heather B Heath, CPC-A Baldwinsville NY
Megan Toman, CPC-A Ballston Lake NY
Suzanne Mary Barnes, CPC-A Ballston Spa NY
Lisa S Berard, CPC-A Binghamton NY
Lorrie A Hagerman, CPC-A Binghamton NY
Marion Louise Hilkert, CPC-A Binghamton NY
Donna M Pitoniak, CPC-A Brewerton NY
Claudia Milena Luna, CPC-A Briarwood NY
Annette A Bazile, CPC-A Brooklyn NY
Nicole DeLucia, CPC-A Brooklyn NY
Michele-Ann E Townsend, CPC-A Brooklyn NY
Kimberly Lee, CPC-A Buffalo NY
Tara B Watkins, CPC-A Buffalo NY
Lauri J Webb, CPC-A, CPC-H-A Buffalo NY
Ronda Tompkins, CPC-A Cameron Mills NY
Ashlee Kay Mawhiney, CPC-A Campbell NY
Gina Theresa Wyffels, CPC-A Canandaigua NY
Teresa Mech, CPC-A Cato NY
Victoria Rodgers, CPC-A Centereach NY
Paulette M Heisler, CPC-A Cheektowaga NY
Linda Daly, CPC-A Chester NY
Michelle HoltJarmacz, CPC-A Chittenango NY
Barbara Kindler, CPC-A Clifton Park NY
Jane F DeMaine, CPC-A Conklin NY
Jackie Malinowski, CPC-A East Amherst NY
Rebecca Orme, CPC-A Elmira NY
Kimberly Q Budney, CPC-A Endwell NY
Patricia Ann Armitstead, CPC-A Fort Plain NY
Amber LaTray, CPC-A Fulton NY
Kristin Schaefer, CPC-A Glenmont NY
Lori Weaver, CPC-A Greenwich NY
Marie Ann Whittaker, CPC-A Guilford NY
Carol R Benjamin, CPC-A Hilton NY
Debra Annmarie Steele, CPC-A Jamaica NY
Patricia W Kohn, CPC-A Johnson City NY
Mary C Smith, CPC-A Jordan NY
Clarissa Campbell, CPC-A Lackawanna NY
Laura Soldani, CPC-A Latham NY
Janelle Grace Shafer, CPC-A Lisle NY
Barbara J Lotito, CPC-A Liverpool NY
Sherry Ann Kenjersky, CPC-A Malden-on-Hudson NY
Sheri Lynn Noble, CPC-A Mattydale NY
Cynthia R Robert, CPC-A Mexico NY
Emily R Schoonmaker, CPC-A Montgomery NY
Margaret Moore, CPC-A Monticello NY
Donna L Smith-O'Connell, CPC-A Moravia NY
Karen Matos, CPC-A New York NY
Nancy Lee Fennhahn, CPC-A North Syracuse NY
Ruth Ellen Thompson, CPC-A Odessa NY
Jay K Jhaveri, CPC-A Old Westbury NY
Catherine Conte, CPC-A Oxford NY
Stephanie E Baisley, CPC-A Queens Village NY
Bonnie Hope Ward, CPC-A Rochester NY
Yvonne K Crandall, CPC-A Smyrna NY
Tina Inman, CPC-A Spencerport NY
Caitlin O'Donnell, CPC-A Staten Island NY
Tracy Ann Luchsinger, CPC-A Syracuse NY
Lynn Marie Knuetter, CPC-A Troy NY
Anne Mccall, CPC-A West Seneca NY
Edward Apanna, CPC-A Westbury NY
Amy L Bowen, CPC-A Whitesboro NY
Carole L Phillips, CPC-A Wilton NY
Theresa R Hemmelgarn, CPC-A Anna OH
Michele Estes, CPC-A Ashtabula OH
Lynn L Asdell, CPC-A Austintown OH
Christine A Vallee, CPC-A Avon OH
Kristine Elaine Kirchner, CPC-A Bedford OH
Melena D Hayes, CPC-A Boardman OH
Scott Storey, CPC-A Broadview Heights OH
Martha Hill, CPC-A Cincinnati OH
Thomas Michael Weber, CPC-A Cincinnati OH
Walisa Brown, CPC-A Cleveland OH
Susan Buchanan, CPC-A Cleveland OH
Angelina Turner, CPC-A Cleveland OH
Renee Weber, CPC-A Cleveland OH
Donna Snell, CPC-A Columbus OH
Barbara Lane, CPC-A Elyria OH
Kelly E Noel, CPC-A Gahanna OH
Judith E Lemmon, CPC-A Girard OH
Teia Nichole Semrock, CPC-A Holland OH
Ashley Renee Cinicola, CPC-A Hubbard OH
Katharine Gedeon, CPC-A Latham OH
Jami L Wolf, CPC-A Lima OH
Janet L Fairhurst, CPC-A Louisville OH
Diane Marie Thompson, CPC-A Louisville OH
Rebecca Ruth Daniel, CPC-A Massillon OH
Andrea Cinicola, CPC-A Masury OH
Dawn Holdgreve, CPC-A Minster OH
Laura Summy, CPC-A Mogadore OH
Christine Clark, CPC-A Monroe OH
Florence Paisley, CPC-A Newton Falls OH
Timothy L Moff, CPC-A Niles OH
Teena Credico, CPC-A Oregon OH
Anata Renee Cooper, CPC-A Painesville OH
Stacy Scarberry, CPC-A Pataskala OH
Kimberly Ann Placek, CPC-A Perrysburg OH
Lisa M Rocco, CPC-A Perrysburg OH
Gina Coman, CPC-A Powell OH
Angela Marghuerite Molyneux, CPC-A Richfield OH
Joshua Seigley, CPC-A Rittman OH
Pamela Brooks, CPC-A Seven Hills OH
Natasha Nicole Moore, CPC-A Toledo OH
Randall Smith, CPC-A Toledo OH
Mona Patterson, CPC-A Westlake OH
Nicole M Gugliotta Riera, CPC-A Willoughby OH
Janice M Zana, CPC-A Willoughby OH
Nicole Danielle Keas, CPC-A Youngstown OH
Stanley Wayne Davis Jr., CPC-A Claremore OK
Jennifer Duckworth, CPC-A Tulsa OK
Ramola Rajagopal, CPC-A Tulsa OK
Angel Westbrook, CPC-A Tulsa OK
Tina Opal Salsedo, CPC-A Albany OR
Shauna Creechley, CPC-A Astoria OR
Darla Bush, CPC-A Beaverton OR
Vivian Rockwell, CPC-A Bend OR
Janet Zancanella, CPC-A Bend OR
Angela Wright, CPC-A Grants Pass OR
Amy Pauline Gagne, CPC-A Gresham OR
Lorri M Findon, CPC-A Happy Valley OR
Kelly Wells, CPC-A La Grande OR
Tami Jane Lock, CPC-A Lyons OR
Jerry Thalhamer, CPC-A McMinnville OR
Julie De Lair, CPC-A Milwaukie OR
Sally Kuntz, CPC-A Milwaukie OR
Michelle L Martinez, CPC-A Oregon City OR
Linda Coates, CPC-A Portland OR
Marsha Costy, CPC-A Portland OR
Dean Dinsmore, CPC-A Portland OR
Lori Irwin, CPC-A Portland OR
Jane Jones, CPC-A Portland OR
Gayle Naumcheff, CPC-A Portland OR
Mihaela Vonica, CPC-A Portland OR
John Lesmeister, CPC-A, CPC-P-A Salem OR
Tiffany Wilson, CPC-A Salem OR
Mary Houck, CPC-A Airville PA
Joan L North, CPC-A Ambridge PA
Kimberly Cunningham, CPC-A Dillsburg PA
Stacy Lynne Rider, CPC-A Dillsburg PA
Danielle Maguire, CPC-A Dover PA
Rose Sedlock, CPC-A Emmaus PA
Lonnie Jean Chivers, CPC-A Felton PA
Donna M Smith, CPC-A Glenside PA
Sarah L Hayman, CPC-A Greenville PA
Paula A Duffy, CPC-A Henryville PA
Nicole Fetterolf, CPC-A Howard PA
Amber Imboden, CPC-A Hummelstown PA
Anuradha Ramaraju, CPC-A Hummelstown PA
Shawna Marie Milbourne, CPC-A Jacobus PA
Jayma Hower, CPC-A Lancaster PA
Susan A Holler, CPC-A Londberg PA
Alyson R Willis, CPC-A Manchester PA
Margaret Kocher, CPC-A Marysville PA
Pam Harding, CPC-A Mechanicburg PA
Donna Jean Grimm, CPC-A Mechanicsburg PA
Angela Dianne Zimmerman, CPC-A Mechanicsburg PA
Phyllis Long, CPC-A Mount Joy PA
Judy Sawtelle, CPC-A Olanta PA
Betsy Shiland, CPC-A Philadelphia PA
Jennifer A Modderman, CPC-A Quarryville PA
Jamie S Rolon, CPC-A Reading PA
Shannon R Leonard, CPC-A Red Lion PA
Rebecca Stevens, CPC-A Red Lion PA
Mary A White, CPC-A Red Lion PA
Amanda Dean, CPC-A Sayre PA
Candy Davis, CPC-A Temple PA
Donna Accetta, CPC-A Walnutport PA
Nancy Carol Keener, CPC-A Wernersville PA
Lori Hoffman, CPC-A York PA
Susan E Lahood, CPC-A York PA
Evangelia Paloukas, CPC-A Riverside RI
Alissa Meagan Da Silva, CPC-A Warwick RI
Melissa Reynolds, CPC-A Westerly RI
Vickie Richardson, CPC-A Bishopville SC
Tiffany Wiley, CPC-A Bishopville SC
Annie Lee Sallee, CPC-A Charleston SC
Thomaseen Patrice Williams, CPC-A Charleston SC
Yulanda W Berry, CPC-A Clover SC
Jason Bentley Clark, CPC-A Columbia SC
Shanitra Rokasha Mason, CPC-A Columbia SC
Pamela S Correll, CPC-A Effingham SC
Colleen Lodato, CPC-A Greer SC
Sharon Pruitt, CPC-A Hanahan SC
Amie Ann Wheat, CPC-A Lake City SC
Susie A Akrong, CPC-A Lexington SC
Jodi Lowder, CPC-A Orangeburg SC
Melissa Pontoo Boyd, CPC-A Simpsonville SC
Dana Hice, CPC-A Simpsonville SC
Patricia Hawkins, CPC-A Spartanburg SC
Angela Smith, CPC-A St Matthews SC
Jonathan Smith, CPC-A St Matthews SC
Faleshia Davis, CPC-A Summerville SC
Jessica Marie Sellers, CPC-A Sumter SC
Timothy Edward Landreth, CPC-A Taylors SC
Juanikia Peterson, CPC-A Timmonsville SC
Lacy Mccoy, CPC-A Walterboro SC
Isaac Mayo, CPC-A Sioux Falls SD
Zoraida Montanez, CPC-A Adams TN
Karen Diane Burrum, CPC-A Antioch TN
Deborah Floyd, CPC-A Antioch TN
Gladys Glenn Mason, CPC-A Antioch TN
Misty Shelton, CPC-A Bethpage TN
Sheila Morton, CPC-A Bristol TN
Johnna Burton, CPC-A Brownsville TN
Rachel Collins Mills, CPC-A Cane Ridge TN
Bonnie Gross, CPC-A Chattanooga TN
Linda Pedrosa Sneed, CPC-A Chuckey TN
Stefani Nichelle Sanders, CPC-A Columbia TN
Kim Ashburn, CPC-A Cookeville TN
Robin Pitts, CPC-A Cookeville TN
Delores Brown, CPC-A Dickson TN
Andrea Lynn Hall, CPC-A Dickson TN
Jody Ludwig, CPC-A Dickson TN
Starr Bryant, CPC-A Duck River TN
Leanne Shelton Charles, CPC-A Franklin TN
Christopher Cameron Jamieson, CPC-A Franklin TN
Lisa Mcpherson, CPC-A Goodlettsville TN
Kim Wilson, CPC-A Hendersonville TN
Constance D Letcher, CPC-A Johnson City TN
Ashley Rene Garton, CPC-A Kingston Springs TN
Phyllis Aileen Biggs, CPC-A Knoxville TN
Stacey Morris, CPC-A Knoxville TN
April Parsons, CPC-A Knoxville TN
Klara Maxine Ware, CPC-A Knoxville TN
Lynette Rae Zimmerman, CPC-A Knoxville TN
Sallie Seymour, CPC-A Maryville TN
Sarah E Glendenning, CPC-A Murfreesboro TN
Amy Burrow, CPC-A Nashville TN
Josh Oconnor, CPC-A Nashville TN
Emily Childers, CPC-A Old Hickory TN
Sheena Maddox, CPC-A Smyrna TN
Colleen Ericksmoen, CPC-A Sparta TN
Misty Temple, CPC-A Arlington TX
Rushunda Selena Lee, CPC-A Austin TX
Kiran N Gupta, CPC-A Brownsville TX
Kathryn M Barr, CPC-H-A Canyon Lake TX
John Alexander, CPC-A Cedar Creek TX
Christi Gray, CPC-A Dallas TX
Christopher Perez, CPC-A El Paso TX
Rigoberto Robles, CPC-A El Paso TX
Christina Rojas, CPC-A El Paso TX
Martha Patricia Venegas, CPC-A El Paso TX
Leslie Pierce, CPC-A Ferris TX
Starla Hooten, CPC-A Forney TX
Stephen Alexander, CPC-A Fort Worth TX
Nancy Cisneros, CPC-A Fort Worth TX
Ebonye Johnson, CPC-A Fort Worth TX
Lola Sample, CPC-A Fort Worth TX
Cassandra Bellovich, CPC-A Frisco TX
Tracy O'Brien, CPC-A Frisco TX
Lien B Nguyen, CPC-A Grand Prairie TX
Julie Fleming, CPC-A Holly Lake Ranch TX
Grace Hawa, CPC-A Houston TX
Victoria L Hurley, CPC-A Houston TX
Jane Jurgens, CPC-A Houston TX
Mary E Ngo, CPC-A Houston TX
Rhonda Schwarz, CPC-A Houston TX
Julie Mcclelland, CPC-A Irving TX
Sandra Chambers, CPC-A Katy TX
Mary Ann Harvey, CPC-A Keller TX
Kathy Joan Palalay, CPC-A Keller TX
Stephanie Ann Boswell, CPC-A Lubbock TX
Nora Cuevas, CPC-A Lubbock TX
Jean Nissen, CPC-A Magnolia TX
Cindi Maria Wilson, CPC-A Mesquite TX
Diptiben Chirag Patel, CPC-A Pearland TX
Chin Ju Fan, CPC-A Plano TX
Chuang-Hua Liu, CPC-A Plano TX
Lorelei Tatom, CPC-A Plano TX
Bryan Warfield, CPC-A Plano TX
Glenda Robison, CPC-A Quinlan TX
Paula Wickliffe, CPC-A Red Oak TX
Donna Marie White, CPC-A Round Rock TX
Dana Craig, CPC-A Rowlett TX
Jamie Barnes, CPC-A San Antonio TX
Alexis Bass, CPC-A San Antonio TX
Erica Soto, CPC-A San Antonio TX
Pratibha Bhula, CPC-A The Colony TX
Starsky Hall, CPC-A The Colony TX
Joyce Hicks, CPC-A Watauga TX
Lin S Livingston, CPC-A Watavga TX
Tammy Dann Suess, CPC-A Webster TX
Crystal Wade, CPC-A Whitehouse TX
Parul, CPC-H-A Rishikesh UK
Cheryl Ipson, CPC-A American Fork UT
Melissa Anne Foster, CPC-A Bountiful UT
Penny Pickett, CPC-A Bountiful UT
Celeste Porter, CPC-A Draper UT
Michelle Bodell, CPC-A Herriman UT
Genesa Bowler, CPC-A Kearns UT
Laurel Walker Huff, CPC-A Kearns UT
Janalene Roseman, CPC-A Morgan UT
Lisa Wibiral, CPC-A Murray UT
Christi Boyles, CPC-A Payson UT
Pamela Mcshane, CPC-A Salt Lake City UT
Diane Smith, CPC-A Salt Lake City UT
Micheline Wood, CPC-A Salt Lake City UT
Rebecca G Burgess, CPC-A Sandy UT
Becky Clawson, CPC-A Sandy UT
Robyn Rytting, CPC-A Sandy UT
Katie Gourdin, CPC-A Smithfield UT
Deon Stroman, CPC-A South Jordan UT
Marchelle Jones, CPC-A South Ogden UT
Natascha Hope Tanner, CPC-A Springville UT
Vickie Lynne Chapman, CPC-A Taylorsville UT
Mona Searle, CPC-A Taylorsville UT
Jami Lee Vaughan, CPC-A, CPC-H-A Taylorsville UT
Kersten Ann Crisp, CPC-A West Jordan UT
Ruth Davidson, CPC-A West Jordan UT
Brenda Lopez, CPC-A West Jordan UT
Megan Murphy, CPC-A West Jordan UT
Alicia Buhecker, CPC-A West Valley UT
Elizabeth Jaquier, CPC-A West Valley UT
Janet Larios, CPC-A West Valley UT
Teresa Flemming, CPC-A West Valley City UT
Danielle Tenny, CPC-A West Valley City UT
Jaimie Jensen, CPC-A Woods Cross UT
Katie An, CPC-A Annandale VA
Gay B Sullivan, CPC-A Arlington VA
Dara Tyler, CPC-H-A Arlington VA
Pamela Hammond, CPC-A Carson VA
Sandra Ann Karger, CPC-A Carson VA
Amanda O Sweetser, CPC-A Chesapeake VA
Elizabeth Ashley Deel, CPC-A Clintwood VA
Amanda Gail Vaughn, CPC-A Dryden VA
Tammy L Sankner, CPC-A Fairfax VA
Patricia Anne Martinez, CPC-A Henrico VA
Amy Klingensmith, CPC-A Highland Springs VA
Catherine T Christopher, CPC-A Kilmarnock VA
Robin Record Sundstrom, CPC-A Maidens VA
Elham Khosravi, CPC-A McClean VA
Denise Conrad, CPC-A Norfolk VA
Shakena L McGill, CPC-A Portsmouth VA
Henry C. Dabbs, CPC-A Richmond VA
Penny N Minor, CPC-A Rockville VA
Pamela F Hall, CPC-A Schuyler VA
Robin Shamblin Pone, CPC-A Seaford VA
Laurie Frye, CPC-A Virginia Beach VA
Sharon B Kelly, CPC-A Virginia Beach VA
Pamela Strawderman, CPC-A Winchestar VA
Abbey Lee Hamblin, CPC-A Wise VA
Ofelia Corpuz, CPC-A Woodbridge VA
Joanna Soucek, CPC-A St Thomas VI
Lisa Echevarria, CPC-A Burlington VT
Kelly Murdock, CPC-A Grand Isle VT
Fawn Whittemore, CPC-A Irasburg VT
Jewell E Froisland, CPC-A Milton VT
Deborah Lorene Dusablon, CPC-A No Hero VT
Karen L Spear, CPC-A Stowe VT
Diane M McGovern, CPC-A Thetford VT
Eva Jussila, CPC-A Brush Prairie WA
Ann Loucks, CPC-A Everett WA
Marlys Boyer, CPC-A Lacey WA
Margaret Harden, CPC-A Olympia WA
Heather Anderson, CPC-A Puyallup WA
Stacy Fundenberger, CPC-H-A Seattle WA
Chuana E Thomas, CPC-A Seattle WA
Teresa Wickliff, CPC-A Seattle WA
Jillian Garza, CPC-A Selah WA
Inez Nightser, CPC-A Spokane WA
Sandra L Nogle, CPC-A Spokane WA
Marie F Evans, CPC-A Tacoma WA
Andrea Hill, CPC-A Tacoma WA
Shannon Ross, CPC-A Tacoma WA
Kathy Ackerson, CPC-A Vancouver WA
Francis Akin, CPC-A Vancouver WA
Geneva Bars, CPC-A Vancouver WA
Debbie Battaglia, CPC-A Vancouver WA
Lori Clark, CPC-A Vancouver WA
Kim Rice, CPC-A Vancouver WA
Tina Schreck, CPC-A Kaukauna WI
Heather Rhoades, CPC-A Madison WI
Rebecca Preston, CPC-A Marshfield WI
Therese Reiff, CPC-A Milwaukee WI
Kristine Moore, CPC-A Wisconsin Rapids WI
Amy R Dodd, CPC-A Bridgeport WV
Evelina L Brumage, CPC-A Bruceton Mills WV
Cheralyn Rohr, CPC-A Buckhannon WV
Destiny Scarberry, CPC-A Charleston WV
Jessica Hope Drabnis, CPC-A Clarksburg WV
Jessica Lee Chandler, CPC-A, CPC-H-A, CPC-P-A Dunbar WV
Ellen Grace White, CPC-A Fairmont WV
Tamara Reynolds, CPC-A Huntington WV
Tara Nicole Trippett, CPC-A Huntington WV
Dale Johnson, CPC-A Milton WV
Tammy Forquer, CPC-A Morgantown WV
Lynda Jean Smith, CPC-A Morgantown WV
Christa Michelle Dillon, CPC-A Red House WV
Melinda C Doyle, CPC-A Scott Depot WV
Regina C Whitehair, CPC-A Thornton WV
Brandi Wilson, CPC-A Walkersville WV
Samantha Sue Jensen, CPC-A Manville WY

Specialties

Alyson Stilwell,
CPC, CHOC Huntsville AL

Brett B Tyhurst,
CPC, CANPC Benton AR

Tammy Helton,
CPC, CPMA, CEMC Farmington AR

Connie E Stubbs,
CPC, CPMA, CEMC Sheridan AR

Valerie G Kambeitz,
CPC, CPMA, CEMC Peoria AZ

Brenda Sue Gilbert-Sanchez,
CPC, CUC Surprise AZ

Angela Maria Maher,
CPC, CPMA, CCC, CEMC Tucson AZ

Genevieve Daley,
CPC, CPC-H, CPC-I, CEMC Chula Vista CA

Drew Alan Dellenbach,
CPC, CHOC, CRHC Corona CA

Lorena Rojas,
CPC, CGIC Fresno CA

Cindy L Wulbern,
CPC, CASCC, COSC, CUC Los Banos CA

Susie L Masten,
CPC-H, CASCC Pleasanton CA

Shelly Albury,
CPCD Roseville CA

Rebecca Renfro,
CPCD Roseville CA

John Hailes,
CPC, CPC-H, CPMA, CPC-I, CEMC, CFPC Sacramento CA

Jennifer T Martinez,
CPC, CPMA, CEMC Sacramento CA
Stephanie A Sutton,
CPC, CPC-H, CEMC Sunnyvale CA
Dale E Cox,
CPC, CPMA, CPC-I, CEMC Aurora CO
Jennifer A Hume,
CPC, CPMA, CEMC Aurora CO
Lisa K Curtis,
CPC, CPMA, CPC-I, CEMC, COBGC Boulder CO
Patricia Kresch,
CPC, CPC-H, CCC Denver CO
Bernadette J Vigil,
CPC, CEDC Lakewood CO
Robyn O'Neal,
CPC, CPMA, CEMC Littleton CO
Cheryl Hedman,
CCC Thornton CO
Kristin Mae Bailey,
CPC, CEMC Westminster CO
Sally Jean Wadlington,
CPC, CPMA, CEMC Windsor CO
Patricia Trautner,
CPC, CEDC Meriden CT
Pamela Walsh,
CPC, CPMA, CEMC Prospect CT
Maria Monserate Santiago,
CPC, CPMA, CEMC Waterbury CT
Rachael Milley,
CPC, CPMA, CEMC Hobe Sound FL
Loida E Collazo,
CPC, CPC-P, CPMA, CEMC, CUC Oviedo FL
Yanhong Robin Shear,
CPC, CGIC Oviedo FL
Beverly J Francis,
CPC, CEMC Palm Harbor FL
Kembrlee Scott Potter,
CPC, CPMA, CEMC, CGSC Pensacola FL
Valarie K Smith,
COBGC Pensacola FL
Amanda Colangelo,
CPCD Pinellas Park FL
Vanessa Hart,
CPCD Pinellas Park FL
Raemarie Jimenez,
CPC, CPMA, CPC-I, CANPC, CRHC Pompano Beach FL
Theresa M Hice,
CPC, COBGC St Augustine FL
John Bishop,
CPC, CGSC, CPRC Tampa FL
Linda C Cribbs,
CPC, CANPC Tampa FL
Armando Colon,
CPC-H, CASCC Winter Haven FL
Christy A Shannon,
CRHC Atlanta GA
Cynthia Lea Herlihy,
CPC, CEMC Dallas GA
Dorothy D Steed,
CPC-H, CPMA, CPC-I, CEMC, CFPC Doraville GA
Martin Yasuda,
CPC, CPMA Aiea HI
Essie White,
CPC, CPC-H, CPMA, CPC-I, CGSC Honolulu HI

Derek Wong,
CPC, COBGC Honolulu HI
Linda Chiu,
MD, MBA, FACS, CPC, CENTC Kailua HI
Adele Miyasato,
CPC, CEMC Pearl City HI
Helene N Bereskin,
CMIS, CPC, CHOC Bettendorf IA
Davey Lee Ehrke,
CPC-H, CASCC Cedar Rapids IA
Linda L Jackson,
CPC, CGIC Clive IA
Gail L Eldridge,
CPC, CPMA, CEMC Boise ID
Marilyn Dianne Hughes,
CPC, CANPC Alton IL
Jennifer V Cunningham,
CPC, CIMC Bloomington IL
Michelle Jubeck,
CPC, CPMA, CEMC Freeport IL
Alison Davis,
CPC, CEMC Mahomet IL
Carrie Lynn Rawlings,
CPC, CPMA, CPC-I, CCVTC, CEMC Mattoon IL
Kelly L Stranko,
CPC, CCVTC, CGSC Mattoon IL
Crisan K Houston,
CPC, CPMA, CCC, CEMC Springfield IL
Kim L Ramirez,
CPC, CPC-H, CPC-I, CEMC Sterling IL
Mariana Abarca,
CPCD Willowbrook IL
Dondi L Wray,
CPC, CPMA, CEMC, CFPC Bloomington IN
Ann Silvia,
CPC, CPMA, CPC-I, CEMC, CFPC Brownsburg IN
Donna Grimm,
CPC, CPCD Carmel IN
Janice Rose Konchalski,
CPC, CPC-H, CFPC, CPEDC Fort Wayne IN
Teresa A Brock,
CPC, CPMA, CEMC Freetown IN
Beverly A Strube,
CPC, CPC-H, CPMA, CPC-I, CEMC, COBGC Indianapolis IN
Cindy L Ward,
CPC, CPC-H, CPMA, CEMC Indianapolis IN
Jennifer Swindle,
CPC, CPMA, CEMC, CFPC Lafayette IN
Dawn Rene Smith,
CPC, CEMC Lebanon IN
Chandra Lynn Stephenson,
CPC, CPC-H, CPMA, CPC-I, CEMC, CFPC, CIMC, COSC Lebanon IN
Sandra L Goodknight,
CPC, CPMA, CEMC South Bend IN
Richelle Beckman,
CPC, CPMA, CEMC Lenexa KS
Karen R Cross,
CPC, CPMA, CEMC, CUC Overland Park KS
Cathy S Jennings,
CPC, CHOC Overland Park KS
Tracy Bird,
CPC, CPMA, CPC-I, CEMC Shawnee Mission KS
Brenda Edwards,
CPC, CPMA, CPC-I, CEMC Topeka KS

Theresa A Burg,
CPC, CPMA, CEMC Covington KY
Tracie Bullock,
CPC, CPC-H, CPMA Kirksey KY
Carrie A Dunn,
CPC, CHOC Louisville KY
Charlotte Kay Lynn,
CPC, CPC-H, COBGC Nebo KY
Priscilla Frost,
CPC, CPMA, CEMC Bossier City LA
Lynn Kimsey,
CPC, CPMA, CPC-I, CEMC Bossier City LA
Victoria M Templet,
CPC, COBGC Metairie LA
Jeannette Connell,
CPC, CEMC Kingston MA
Paula A Lind,
CPC, CPMA, CEMC Millbury MA
Carolin Collymore,
CPC, CPMA, CEMC Roslindale MA
Catherine Opielowski,
CPC, CANPC Springfield MA
Tracy Staples,
CPC-H-A, CASCC Springfield MA
Angela L Arena,
CPC, CEMC Wrentham MA
Atena Artenie,
CPC, CEMC Arnold MD
Betsy Marie Lewis,
CPC, CANPC, CASCC Pasadena MD
Deborah Zarick,
CPC, CPMA, CPC-I, CEMC Walkersville MD
Krystle D E Brown,
CPC, CPC-H, CPMA, CEMC Windsor Mill MD
Deena Moreau,
CPC, CGSC Jay ME
Vonda Johnson,
CCC Farmington Hills MI
Laura Lee Lovett,
CPC, CPMA, CEMC Fenton MI
Terri Arendt,
CASCC Fowlerville MI
Judy B Breuker,
CPC, CPMA, CEMC Hudsonville MI
Gloria Ann Cook,
CPC, CEMC Lansing MI
LuAnn C Jenkins,
CPC, CPMA, CEMC, CFPC Lapeer MI
Lori Code,
CPC, CCC Livonia MI
Joseph L Rivet,
CPC, CPMA, CEMC Livonia MI
Kelli S Annis,
CPC, CPMA, CEDC, CEMC, CIMC Marshall MI
Sandy Prince,
CPC, CFPC Menominee MI
Tina Erickson,
CPC, CPMA, CEMC Farmington MN
Katherine A Nulph,
CPC, CANPC Columbia MO
Stephany Renee Kelow,
CPC, CPMA, CEDC, CEMC Raytown MO
Pamela J Samuels,
CPC, CANPC Sedalia MO
Amy E Bishard,
CPC, CPMA, CEMC Springfield MO

Rebecca Ann Murphy,
CPC, CPMA, CEMC Hattiesburg MS
Quietha Rodgers,
CHOC Meridian MS
Beth ReAnne Gentry,
CPC, CPMA, CEMC Poplarville MS
Rosetta Ross,
CHOC Carthage NC
Holly Oehler,
CPC, CFPC Charlotte NC
Deann Tate,
CPC, CEMC Charlotte NC
Wendy Parker Wright,
CPC, CPMA, CEMC Gastonia NC
Charla Prillaman,
CPC, CPMA, CPC-I, CCC, CEMC Indian Trail NC
Cindy Roberts,
CPC, CPCD Kings Mountain NC
Sherry Lingerfelt Brown,
CPC, CPMA Lincolntown NC
Nancy G Higgins,
CPC, CIRCC, CPMA, CPC-I, CEMC Monroe NC
Tiffany Henderson Spencer,
CPC, CPMA, CEMC, CHOC Monroe NC
Arlene J Yergler,
CPC, CPC-I, CEMC Morganton NC
Kathy Johnson,
COBGC Reidsville NC
Jana Rakes,
CPC, CEDC Timberlake NC
Suzanne M Baker,
CPC, CPMA, CEMC Wendell NC
Amy Vaughan Oehler,
CPC, CFPC Charlotte ND
Tanna McMillan,
CPC, CPMA Omaha NE
Mekell Turner,
CPC-A, CPMA Belleville NJ
Tina Cressman,
CPC, CPC-H, CPC-P, CPMA, CPC-I, CEMC Cherry Hill NJ
Debra Gordon Packer,
CPC, CPMA Fair Lawn NJ
Nicole Ciemniecky,
CGSC Hillsborough NJ
Nicole A Capalbo,
CPC, CPMA Little Falls NJ
Srividya Balaji,
CPC, CPMA Short Hills NJ
Michael Strong,
CPC, CEMC Whiting NJ
Sue Hutton,
CPC, CEMC Albany NY
Janelle Lynn Cecchini,
CPC, CPMA, CEMC Buffalo NY
Roberta L Bosanko,
CPC-P, CPMA, CEMC New York NY
Sonnia M Marmol,
CPC, CPMA New York NY
Pamela L Uvanni,
CPC, CPEDC Rome NY
Deborah Tweedy,
CPC, CANPC Canton OH
Carrie Weiss,
CEMC Columbus OH
Maria L Douglas,
CPC, CPMA, CEDC Mantua OH

Claire Cieri,
CPC, CEMC Eugene OR
Kathy Beach,
CEDC Newberg OR
Kathryn Marie Anderson,
CPC, CPMA, CEMC Portland OR
Marsha McGraw,
CRHC Portland OR
Nelda Ortega,
CCC Roseburg OR
Kelley Hawes,
CUC Springfield OR
Margaret Ann Bronowicki,
CPC, CEMC Allentown PA
Rebecca Ann Queer,
CPC, CPMA, CEMC, CGIC, CGSC, COBGC Clarion PA
Tracey Christine Glenn,
CPC, CPC-H, CPMA, CEMC Harrisburg PA
Jennifer Spangler,
CPC, CFPC Hummelstown PA
Sandra Dudley,
CPC, CPMA, CEMC Mechanicsburg PA
Patricia A Gansberger,
CPC, CCC Pittsburgh PA
Rhonda Buckholtz,
CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC Seneca PA
Shawna Marie Pistner,
CPC, CASCC St Marys PA
Susan L Rice,
CPC, CPC-H, CHOC Johnston RI
Michele R Hayes,
CPC, CPMA, CEMC, CGIC Anderson SC
Kaye Blue Johnson,
CPC, CEMC Florence SC
Susan J Morton,
CPC, CEMC, CGSC Greenville SC
Nichole Davis,
CPC, CPMA, CEMC Summerville SC
Stephanie MacReynolds-Parmelee,
CPC, CEMC, CHOC Salem SD
Donna Worley,
CPC, CPC-H, CPMA, CEMC, COBGC Chattanooga TN
Cheryl C Davis,
CPC, CHOC Cottontown TN
Tiffany Lynne Beaty,
CPC-A, CEDC Maryville TN
Deedra Garrison,
CPCD Maryville TN
April Attig,
COSC Nashville TN
Dawn Peck,
CPC, CPCD Nashville TN
Caren Zuniga,
COBGC Austin TX
Jashona Mitchell,
CPC, CPEDC Bay City TX
Kelly Skinner,
CPC, CFPC Eastland TX
Patricia Gutierrez,
CPC, CUC El Paso TX
Sengmany Susie Ma,
CCC Houston TX
Hilda Talbot,
CPC, CCVTC Houston TX
Amy Powell Gross,
CRHC Navasota TX

Mathukutty J Kariampally,
CEDC Pearland TX
Natalie Jessica Moya,
CPC, CPC-H, CPC-P, CPMA, CPC-I, CEMC Pearland TX
Lisa D Tieu,
CPC, CPMA, CEMC, CGIC Pearland TX
Linda D Hallstrom,
CPC, CPMA, CPC-I, CEMC Plano TX
Sherry Wilson,
CIRCC, CPMA Spring Branch TX
Deborah Grider,
CPC, CPC-H, CPC-P, CPMA, CPC-I, CEMC, COBGC, CPCD Draper UT
Nannette Orme,
CPC, CPMA, CEMC Orem UT
Brandi Suthar,
CPC, CANPC West Jordan UT
Diana Stuart,
CPC, CPC-H, CPMA, CEMC Carrollton VA
John D Uecke,
CPC, CPMA Chantilly VA
Rose Moore,
CPC, CPMA, CPC-I, CEMC Chesterfield VA
Joanne M Austin,
CPC, CIMC Crewe VA
Patricia A Cox,
CPC, CPC-H, CPMA, CPC-I, CEMC Gloucester VA
Sarah Alison Bowen,
CPC, CPMA Mechanicsville VA
Amy Lee Smith,
CPC, CPC-H, CPMA Newport News VA
Rosalie Riley,
CPC, CPMA, CEMC Sterling VA
Monica Rae Bowman,
COSC Colbert WA
Janae Elizabeth Ballard,
CPC, CPC-H, CPMA, CEMC Federal Way WA
Regan Bode,
CPC, CPC-H, CPMA, CEMC Redmond WA
Cori Jo Green,
COSC Spokane WA
Dawn R Madsen,
CPC, CENTC Spokane WA
Kimberly Nichols,
CPC, COSC Spokane WA
Deborah K Roundy,
CPC, CPC-I, CEMC Spokane WA
Tamara Oliverson,
CPC, CPCD Spokane Valley WA
Susan L Reehill,
CPC, CPMA, CEMC Tacoma WA
Diana L Simmons,
CPC, CHOC Tacoma WA
Kevin T Humphrey,
CPC, CGSC Delavan WI
Sara Marie McComas,
CPC, COBGC Barboursville WV
Tammy S Chidester,
CPC, CPMA, CEMC Buckhannon WV
Tonia Flohr,
CPC, CHOC Fairmont WV

Road Map to ICD-10-CM
Version 5010: More Than a Software Update

Version 5010: More Than a Software Update

Without Version 5010, ICD-10 implementation can't happen at your practice.

By Deborah Grider,
CPC, CPC-I, CPC-H, CPC-P, CPMA, CEMC, COBGC, CPC-D, CCS-P

In February's Road map to ICD-10, we focused on ICD-10's impact on your practice or facility and how to get ready. Now, let's focus on the impact of Version 5010 implementation.

Version 5010 of the electronic data interchange (EDI) must be implemented no later than Jan. 1, 2012. Lately, you might see a focus on getting ready for 5010 implementation. This is an important first step to ICD-10 implementation success.

Know 5010's Importance

If you are unfamiliar with Version 5010, here is its background. The Health Care Insurance Portability and Accountability Act (HIPAA) requires the Secretary, U.S. Department of Health and Human Services (HHS) to adopt standards for all covered entities to use when conducting certain health care administrative transactions electronically. These include claims, remittance, eligibility, and claims status requests and responses. The current transaction standard is x12 Version 4010A. This version is outdated and will not work with ICD-10. Version 5010 is marked for improvement. According to HHS proposed rule (*Federal Register*, Vol. 73, No. 164, Aug. 22, 2008), "operational and technical gaps still exist in Version 4010A. In addition, it has been more than 5 years since implementation of the original standards, and business needs have evolved during this time." To migrate to ICD-10, Version 5010 implementation is necessary as Version 4010A cannot accommodate the expanded code sets of ICD-10-CM and ICD-10-PCS.

Benefits of Transitioning to 5010

The switch to Version 5010 EDI architecture allows for transaction differentiation between ICD-9-CM and ICD-10-CM/PCS. Many of Version 5010's changes will correct deficiencies in Version 4010A.

Version 5010 has four basic changes from 4010A:

- Front matter—identifies the purpose and business information related to transactions.
- Technical—assures that transmitted data is more understandable.
- Structural—modifies the physical components of the transaction. For example, the name segment which includes a first, middle, last name, and name prefix and suffix.
- Data content improvement—allows for ICD-10-CM/PCS code sets support.

Version 5010:

- Improves clarity in provider loops (or fields);
- Supports ICD-10-CM/PCS;
- Clarifies National Provider Identifier (NPI) instructions;
- Requires guarantor/dependent information on eligibility responses;
- Improves coordination of benefit (COB) transactions by telling payers which transactions are primary versus secondary, enabling correct provider payment during the initial submission;
- Reduces "syntax error" related denials;
- Improves tracking;
- Allows for multiple identifiers;
- Limits responses to the claims where an inquiry is made;
- Introduces 45 new service type codes; and
- Provides improved usability for eligibility transactions (specifically the 270 and 271 eligibility responses).

Electronic transaction code sets are used in the physical transmission of health care data. ICD-10-CM will be the code set used to identify specific diagnoses in submission of claims, related transactions, and clinical reporting.

Because Version 4010A cannot accommodate the seven digits of specificity that exists in ICD-10 (versus the five digits in ICD-9), Version 5010 is a prerequisite to ICD-10-CM and ICD-10-PCS implementation.

Version 5010 also promises to decrease the time staff currently spend looking up information and making phones calls to verify eligibility, claim denials, and appeals.

Ensure Readiness

Version 5010 is more than a software update. Many organizations will require practice management and electronic health record (EHR) system upgrades. The American Recovery and Reinvestment Act of 2009 (ARRA) financial incentives for physicians who adopt an EHR make this a great time to do it. As a bonus, the conversion will drive automation and increase reporting of quality performance measures. This is something to think about considering administrative and clinical data may be required for quality measures in the future. Clinical data could be the driving factor for payment of claims and performance bonuses.

If you think your vendor will contact you with the upgrade, you are wrong. You must contact your vendor and find out its progress. Ask your vendors for guidance, "What do I need to do to get ready?" Again, this is not a simple software upgrade. If you don't implement 5010 by the deadline, your claims will not be processed and this will affect the financial health of your organization.

Important: *D0 N0T* expect regulatory delays for Version 5010 or ICD-10 implementation—CMS begins testing 5010 this spring. Non-compliance of this HIPAA mandate is punishable by fines, which are a minimum of $100 per transaction, up to $50,000 a year annually, per transaction. Get on your vendor's schedule for guidance, implementation, testing, and training.

For Version 5010 and ICD-10 implementation industry milestones, see **Table A**.

Table A: Timeline for Version 5010 and ICD-10 Implementation

Target Date	Milestone
January 2009	Begin level 1 activities (gap analysis, design, and development).
January 2010	Begin internal testing for version 5010. Begin initial ICD-10 implementation and compliance activities.
December 2010	Achieve level 1 compliance (covered entities have completed internal testing and send and receive compliant transactions; includes software vendors, providers, and clearinghouses).
January 2011	Begin level 2 testing activities (external testing with trading partners and move into production: dual 4010A1/5010 processing mode).
Jan. 1, 2012	Full compliance with 5010. Transition must be complete.
Oct. 1, 2013	Full compliance with ICD-10. Compliance must be complete. ICD-9-CM codes will not be accepted for service dates on or after Oct. 1, 2013.

Typically, these activities are performed by your vendors. If your organization employs information technology (IT) staff, who either have built or customized your system(s), it is important to understand what activities must occur. If you are using vendors for your systems, including practice management, financial, EHR, etc., it is important to have an idea where they are in the process toward compliance.

Level 1 activities include:

- Timeline development
- Gap analysis
- Project charters, budgets, and work plans
- System design specification
- Development and internal testing
- Software delivery
- Internal testing (provider)
- Transaction certification in preparation for level II activities
- Begin ICD-10 implementation activities

Level 2 activities include:

- External testing between trading partners (provider, clearinghouse, and payers)
- Migration to production following successful testing with each payer
- Begin ICD-10 implementation activities
- Full compliance

Organization-wide training is crucial after implementation and testing, not only for the vendors but for anyone involved in the billing process for new content usage. To assure individuals can properly handle the transactions after Jan. 1, 2012, train them well in advance.

Version 5010 Implementation Tips:

Start early	Begin the process now
Perform a gap analysis (This is CRITICAL)	Identify new content applicable to your organization. Identify deleted content—how does it impact your organization? Identify changed content. Identify business issues and determine their impacts.
Engage your vendors early	Identifying issues early provides the vendor with time to react to the problems or issues at hand. Vendors may view a guide requirement or situation differently than the provider. Be persistent with your requirements and interpretation.
Communication	Communicate and coordinate with your trading partners early and often. Contact all your vendors for their timeline and roll-out plan. Push them for timely delivery of HIPAA compliant solutions. Contact trading partners to determine readiness and testing. Collaborate with vendor to resolve issues. Join your vendor user-group meetings—this also will help with ICD-10 implementation issues. Resolve business issues early and communicate solution to your trading partners. Many business problems can be averted if identified early.
Testing	Early testing with trading partners is critical. It is important to understand testing timelines to coordinate with the organization. Determine if you need new contract agreements. Review payer specifications outlining their expectations. Make necessary adjustments and resolve problems with payers. Address other technical or business-related issues.
Implementation	Start with your highest volume payer and test with production data. Resolve all problems and differences and move into production. As payers become ready, repeat the process with each payer. Monitor progress to ensure you have all payers into production by January 2012—this might take many months. Test again with several payers closer to the compliance date.

Time to Assess Vendors

Engage your vendors now for 5010 implementation. If a vendor says they will not be ready or do not have a timeline established, think about changing vendors. Find out if your vendors are providing this update at "no charge" or if there is a fee for the update.

Remember: It is *YOUR* responsibility to ensure HIPAA compliance, not the vendor. Get ready. Get set. Implement!

Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPC-D, CCS-P, is the AAPC's vice president of strategic development and the former AAPC National Advisory Board president. Deborah is the author of *ICD-10-CM Implementation Guide, Make the Transition Manageable*, American Medical Association Press, 2009.

Upside-down ads are hard to ignore ...

... So is ICD-10

According to industry experts, it will take up to three years to fully prepare for ICD-10 implementation. If you don't have a plan, you're already falling behind. The AAPC can help you get back on schedule.

Log on to **www.aapc.com/ICD-10** now to learn more.

American Academy of Professional Coders

1-800-626-CODE

2010 PQRI Moves Forward

CMS adds more measures and new reporting mechanisms to maximize revenue and patient care.

By Julie Orton Van, CPC, CPC-P, CEMC, CGSC, COBGC

PROFESSIONAL

Each year, the Centers for Medicare & Medicaid Services (CMS) implements the Physicians Quality Reporting Initiative (PQRI) through a rulemaking process published in the *Federal Register*. In general, CMS has responded positively to provider feedback and continues to provide educational opportunities and implementation resources to encourage better participation. They have endeavored each year to address system and reporting difficulties.

For 2010, PQRI includes several key changes, including:

More Quality Measures

For 2010, CMS adds 30 new, individual PQRI measures and six measures groups on which individual eligible professionals (EPs) may report. The added individual measures are identified in table 13 (pages 93 and 94) of the Nov. 25, 2009 *Federal Register*. The six new measures groups include:

- Coronary Artery Disease (CAD)
- Heart Failure
- Ischemic Vascular Disease (IVD)
- Hepatitis C
- Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)
- Community Acquired Pneumonia (CAP)

A complete listing of 2010 measures groups may be found in the Nov. 25, 2009 *Federal Register*, tables 15-27 (pages 97-103).

Group Practice Reporting

Group practices that satisfactorily report data on PQRI measures are eligible to earn a PQRI incentive payment equal to 2 percent of the group practice's total estimated Medicare Physician Fee Schedule (MPFS) allowed charges for covered professional services furnished during the 2010 reporting period. For instance, if the group practice meeting the participation criteria successfully reports total estimated allowed MPFS charges of $940,000, the practice's total earned incentive amount would be $18,800.

To participate in the 2010 PQRI group practice reporting option (GPRO), a group practice—defined as "consisting of 200 or more individual EPs who have reassigned their billing rights to the TIN [Tax Identification Number]"—must have submitted a self-nomination letter to CMS prior to Jan. 31, and must have been selected to participate in the 2010 PQRI GPRO.

Each group practice selected to participate in the 2010 PQRI GPRO is required to report 26 quality measures, from five measures groups unique to the GPRO:

1. Diabetes Mellitus (DM) Disease Module (eight measures)
2. Heart Failure (HF) Disease Module (seven measures)
3. Coronary Artery Disease (CAD) Disease Module (four measures)
4. Hypertension (HTN) Disease Module (three measures)
5. Preventive (Prev) Care Measures (four measures, individually sampled)

The reporting mechanism is a pre-populated data collection tool CMS provides. Group practices must complete the tool for the first 411 consecutively-ranked and assigned patients in the order in which they appear in the group's sample for each disease module or preventive care measure.

As in past years, EPs who are reporting as individuals do not need to sign up or pre-register to participate in the PQRI. To participate, EPs may choose to report information on individual PQRI quality measures or measures groups to CMS:

(1) On their Medicare Part B claims,

(2) Through a qualified PQRI registry, or

(3) Via a qualified electronic health record (EHR) product.

Individual EPs who meet the criteria for satisfactory submission of PQRI quality measures data using any of these reporting mechanisms for services furnished during a 2010 PQRI reporting period will qualify to earn a PQRI incentive payment equal to 2 percent of their total estimated MPFS-allowed charges for covered professional services furnished during the reporting period. For example, if Dr. Doe reports a sufficient number of measures, reported at 80 percent, and his total estimated allowed MPFS charges are $80,000, his total earned incentive amount would be $1,600.

PQRI Background

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI). The PQRI was further modified as a result of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (MMSEA) (Pub. L. 110-275) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275).

The PQRI program requirements and measure specifications for the current program year are different from the PQRI program requirements and measure specifications for a prior year. EPs are responsible for ensuring they are using the PQRI documents for the correct program year.

An important note: An individual EP who is a member of a group practice selected to participate in the PQRI GPRO is not eligible to earn a separate, individual PQRI incentive payment. When a group practice (TIN) is selected to participate in the GPRO, this is the only PQRI reporting method available to the group and all individual NPIs who bill Medicare under the group's TIN.

EHR Reporting Mechanism

In addition to the claims-based and registry-based reporting mechanisms, CMS will accept PQRI quality measures data extracted from a qualified EHR product on 10 individual PQRI measures, and will—for the first time—allow EPs to count their submission of EHR-based measures toward their eligibility for a PQRI incentive payment.

The final rule provides that EPs who satisfactorily report data on at least three of the 10 EHR-based individual PQRI measures are eligible for an incentive payment. In previous years, EHR-based measure submission has been on a voluntary or pilot basis, and has not counted towards an EP's eligibility for an incentive payment. The addition of an EHR-based reporting mechanism is meant to promote the adoption and use of EHRs, and to provide EPs and CMS with experience on EHR-based quality reporting.

To qualify for PQRI reporting eligibility, a registry or EHR product must go through a self-nomination and vetting process (if they are new to PQRI registry reporting), or must notify CMS of their desire to continue PQRI data submission in 2010 (if they were qualified in 2009 and successfully submitted their users' quality data). Some EHRs also can report the electronic prescribing measure. In addition to capturing the required data elements for the measure calculation, these qualified EHR products also can transmit the required information in the requested file format.

See the Resource Tips at the end of this article for a list of qualified registries for CMS 2010 PQRI reporting.

New, Six-month Reporting Period for Individual Measures

A six-month period for claims-based reporting of individual measures begins July 1. In prior years, the six-month reporting period was available only for measures group reporting or for registry-based reporting.

Success Depends on Meeting the Threshold

PQRI incentive payments are issued separately as a single consolidated incentive payment in the following year. Before an EP can receive an incentive payment for reporting 2010 quality data, however, he or she must meet specific reporting thresholds that depend on the reporting period and option used.

For those EPs who use the claims-based reporting method of individual measure(s), CMS determines whether the provider reported quality data for measures satisfactorily as a general validation. After CMS has determined that the provider submitted valid quality data codes (QDCs), the agency determines if the EP should have submitted QDCs for additional measures using a two-step Measure-Applicability Validation (MAV) process.

For example, if the provider submits quality data for Measure 1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus, CMS will assume other measures related to care of patients with chronic diabetes mellitus are applicable to that practice.

Additional information on the MAV process can be found on the Analysis and Payment page of the PQRI section of the CMS website at www.cms.hhs.gov/PQRI.

PQRI Feedback Reports

Each year, the PQRI incentive payment and the PQRI feedback report are issued through separate processes. PQRI feedback report availability is not based on whether an incentive payment was earned. Feedback reports will be available for every TIN under which at least one eligible professional (identified by his or her NPI) submitting PFS claims reported at least one valid PQRI measure at least once during the reporting period. PQRI participants will not receive claim-level details in the feedback reports.

Following the distribution of 2010 incentive payments, CMS will (as required by the Medicare Improvements for Patients and Providers Act (MIPPA)) post on its website the names of EPs and group practices that satisfactorily report quality measures.

PQRI is a good way to maximize revenue while adding to data important for improved patient care. Although the group practice deadline has passed for 2010, individual EPs are still able to participate and earn payments for this year. And it's not too late for any practice to begin planning for 2011.

Julie Orton Van, CPC, CPC-P, CEMC, CGSC, COBGC, works at Ingenix as a product manager. She has more than 25 years experience in the health care industry, including physician office management, home health and hospice, managed care, laboratory services, physician and facility contracting, benefits administration, and claims payment, clinical information systems. Prior to Ingenix, she was a systems analyst for a fully integrated electronic medical record (EMR) at a large teaching hospital and health care system. She can be reached at Julie.Van@Ingenix.com.

Resource Tips:

The 2010 PQRI program was finalized in the 2010 PFS final rule with comment period (74 FR 61788 through 61844). The final regulation was published in the Federal Register on Nov. 25, 2009 (http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf).

A comprehensive array of PQRI resources is available on the CMS website. CMS educational resources include *MLN Matters* articles, PQRI Educational Products, PQRI National Provider Call PowerPoint Presentations, PQRI Tool-Kit, PQRI Tip Sheets, PQRI Fact Sheets, PQRI Portal User Guide, PQRI FAQs, physician listserves, implementation advice, a single-source code master, web-based training, and more.

Eligible Professionals
www.cms.hhs.gov/PQRI/Downloads/EligibleProfessionals.pdf

Group Practice Reporting Option
www.cms.hhs.gov/PQRI/22_Group_Practice_Reporting_Option.asp#TopOfPage

2010 Registry Requirements
www.cms.hhs.gov/PQRI/Downloads/2010RegistryRequirementsFinal_1(2).pdf

2010 Qualified Registries
www.cms.hhs.gov/PQRI/Downloads/QualifiedRegistriesPhase1Rvsd120709_1.pdf

2010 PQRI EHR Measure Specifications
www.cms.hhs.gov/PQRI/Downloads/2010_EHR_Measure_Specifications_121809.pdf

Qualified EHR Vendors for 2010 PQRI and Electronic Prescribing Incentive Programs
www.cms.hhs.gov/PQRI/Downloads/QualifiedEHRVendorsRvsd01042010Final.pdf

Feedback Report Examples
www.cms.hhs.gov/PQRI/Downloads/2007Re-Runand2008PQRIFeedbackReportExamples.zip

Educational and Support Resources
www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage
www.cms.hhs.gov/PQRI/Downloads/PQRI-eRxEPQuickRefGuideDiagram_100209.pdf
www.cms.hhs.gov/MLNGenInfo/

Acting Controller

Meet the AAPC Staff
Wei Guo

My name is Wei Guo, and I am from China. Before I came to the United States, I was a commercial loan officer for China Construction Bank, which is one of the four biggest banks in China. I received my master's degree in accounting from Utah State University.

I work in the finance department at AAPC as acting controller. My responsibilities include: financial report, human resource and payroll, and management of the Finance Department. Before I joined AAPC, my experience was mainly in the lending industry. It took me some time to learn about:

- Medical coding
- Our many credentials (CPC®, CPC-H®, CPC-P®, CIMC™, CCC™, CASCC™, CGSC™, etc.)
- All kinds of medical terms (ICD-9, HCPCS, E/M, etc.)
- Each department (PMCC, conference, workshop, exam, CEU, etc.)
- Each service offered to our members

It's been three years since I joined AAPC and in that time I have been responsible for its financial health. I am amazed by the company's rapid growth and I am so proud when I see the membership increase and more variety of services provided to coders. I love working for AAPC.

In our department, we have Amy Romero and Dawn Eden doing the data entry, Jan Call doing mail fulfillment and check deposit, and Nicole Egbert doing accounts payable. When you send payments and applications by mail, Jan deposits the check payments and scans paper work into our database system. Our data entry team is responsible for applying your payments appropriately, and making sure all data is accurate in the system. We do our best to process your payments timely and accurately so you receive ordered books, register your online courses to prepare for exams, register for exams, and earn your credentials. We are a strong team, standing behind you with support and want your experience with AAPC to be positive.

Left to right: Nicole Egbert, Amy Romero, Wei Guo, Dawn Eden, and Jan Call

Up Close and Personal

How do you spend your spare time?
In my spare time, I love cleaning my house and organizing stuff. I enjoy cooking healthy and nutritional meals for my family, watching my daughter ice skating, and playing piano. Vacations with my family are always enjoyable.

If you could do any other job what would it be?
I would like to be a professional organizer. I love everything to be neat, clean, and organized. Life would be wonderful with that.

CMS Rehabilitates CR, ICR, and PR Guidelines

By G. John Verhovshek, MA, CPC

Claiming these special services requires renewed understanding of their differences and similarities.

To comply with Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requirements, the Centers for Medicare & Medicaid Services (CMS) updated chapter 32 of the *Medicare Claims Processing Manual* to define coverage and appropriate coding for cardiac rehabilitation (CR) programs, intensive cardiac rehabilitation (ICR) programs, and pulmonary rehabilitation (PR) programs for Medicare beneficiaries. These updates are outlined extensively in the 2010 Medicare Physician Fee Schedule (MPFS) final rule, published in the Nov. 25, 2009 *Federal Register* (http://edocket.access.gpo.gov/2009/pdf/E9-26502.pdf).

Follow CR Rules

CR is a "lifestyle modification" program that aims to stabilize or reverse the progression of cardiovascular disease, and to reduce a patient's heart disease or chance of a cardiac event or death. As defined in Publication 100-04, *Medicare Claims Processing Manual,* chapter 32, section 140 (revised Dec. 11, 2009), Medicare covers CR in a physician's office or a hospital outpatient setting for patients who have experienced **at least** one of the following:

- Acute myocardial infarction within the preceding 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris
- Heart valve repair or replacement
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting
- Heart or heart-lung transplant

To qualify for Medicare coverage, a CR program must include **all** of the following:

- Physician-prescribed exercise each day CR items and services are furnished;
- Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to patients' individual needs;
- Psychosocial assessment;
- Outcomes assessment; and
- An individualized treatment plan detailing how components are utilized for each patient.

The 2010 MPFS final rule further specifies, "The items and services furnished by a CR program are individualized and set forth in written treatment plans that describe the patient's individual diagnosis; the type, amount, frequency, and duration of items and services furnished under the plan; and the goals set for the individual under the plan. **These written plans must be established, reviewed, and signed by a physician every 30 days**." [emphasis added]

Regulations limit CR programs to a maximum of two, one-hour sessions per day, to a maximum total of 36 sessions within 36 weeks. An additional 36 sessions over an extended time also may be covered, if approved specifically by the local Medicare contractor.

To report CR services, call on CPT® 93797 *Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)* or 93798 *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)*, depending on whether electrocardiogram (ECG) monitoring occurs.

Providers should document the length of each CR session (ideally, this would include both start and stop times). The minimum time requirement to report an initial session is 31 minutes. To report two CR sessions on the same day, however, the minimum combined CR time must equal 91 (not 62) minutes. The *Medicare Claims Processing Manual* further specifies, "If several shorter periods of cardiac rehabilitation services are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments."

For example, if the patient receives 20 minutes of cardiac rehabilitation services in the day, CR may not be reported because the minimum time requirement was not met. If, however, the patient receives 20 minutes of cardiac rehabilitation services in the morning and 30 additional minutes later the same day, one session of CR may be reported.

In all cases, CR services must be provided under a physician's direct supervision. That is, a physician must be immediately available and accessible for medical consultations and emergencies during all timed items. Documentation should reflect that this requirement has been met.

ICR Abides Slightly Different Guidelines

ICR includes the same items and services under many of the same conditions (listed above), including the physician supervision requirements, as a CR program. ICR sessions are, however, "furnished in highly structured environments in which sessions of the various components may be combined for longer periods of CR and may be more rigorous," according to CMS in the 2010 MPFS final rule.

To gain necessary Medicare approval, an ICR program must demonstrate through peer-reviewed published research that it accomplished at least one of following for its patients:

- Positively affected the progression of coronary heart disease
- Reduced the need for coronary bypass surgery
- Reduced the need for percutaneous coronary interventions

According to the *Medicare Claims Processing Manual*, an ICR program also must "demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures …"

- Low-density lipoprotein
- Triglycerides
- Body mass index (BMI)
- Systolic blood pressure
- Diastolic blood pressure
- The need for cholesterol, blood pressure, and diabetes medication

HCPCS Level II gained two new codes in 2010 for reporting ICR services: G0422 *Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session* and G0423 *Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session*.

Frequency rules differ for CR, ICR: Unlike a CR program, an ICR program may include up to 72, one-hour sessions, with up to six sessions per day, over a period of up to 18 weeks.

These are time-based codes and, as such, a minimum service time of 31 minutes is required to report the first unit of either G0422 or G0423, as follows:

Total Time	Total Units
< 31 minutes	0
31-90 minutes	1
91-150 minutes	2
151-210 minutes	3
211-270 minutes	4
271-330 minutes	5
> 331minutes	6 (daily maximum)

Once again, CMS says that if several shorter periods of ICR services are furnished on a given day, "the minutes of service during those periods must be added together for reporting in one-hour session increments."

For example, if a patient receives 70 minutes of ICR services without exercise in the morning, and 95 additional minutes of ICR later that same day, correct coding would be G0423 x 3.

As with CR and ICR programs, PR items and services must be furnished in a physician's office or in a hospital outpatient setting, and require a physician's direct supervision.

PR Coverage for COPD Patients

In addition to CR and ICR programs, Medicare offers coverage for PR items and services for patients with moderate to very severe chronic obstructive pulmonary disease (COPD) (those defined as GOLD classification II, III, and IV).

PR programs must be requested by the physician treating the COPD, and must include the following:

- Physician-prescribed exercise. Some aerobic exercise must be included in each pulmonary rehabilitation session;
- Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling;
- Psychosocial assessment;
- Outcomes assessment; and
- An individualized treatment plan detailing how components are utilized for each patient.

As with CR and ICR programs, PR items and services must be furnished in a physician's office or in a hospital outpatient setting, and require a physician's direct supervision.

A single HCPCS Level II code, G0424 *Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session*, reports PR services. A maximum of two, one-hour sessions may be reported per day. The minimum service time to report one hour of service is 31 minutes. The minimum service time to report two hours of service is 91 minutes.

For example, according to the *Medicare Claims Processing Manual*, "If the patient receives 70 minutes of pulmonary rehabilitation services in the morning and 85 minutes of pulmonary rehabilitation services in the afternoon … report two sessions of pulmonary rehabilitation services under the HCPCS G code for the total duration of pulmonary rehabilitation services of 155 minutes. A maximum of two sessions per day may be reported, regardless of the total duration of pulmonary rehabilitation services."

G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.

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

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

CMS Clarifies
Meaningful Use and Eligible Providers

Criteria will be phased into three stages, each building upon another.

By Janice G. Jacobs, CPA, CPC, CCS, ROCC

EPs must participate in either the Medicare or Medicaid incentive program. Eligible hospitals may participate in both.

The term "meaningful use" in reference to the stimulus payment for electronic health records (EHRs) has been a source of confusion for providers who want criteria compliance with the incentive. To clarify further, Congress established the following three requirements for meaningful use:

1. Using EHRs in a meaningful manner

2. Interoperability to enhance the quality of care provided to (a) patient

3. The ability to report quality measures to the Centers for Medicare & Medicaid Services (CMS)

CMS plans on phasing the meaningful use criteria in three stages, building upon one another. The first stage begins in 2011, the second stage in 2013, and the third and last stage in 2015. Advances in health information technology (HIT) will be incorporated into each subsequent stage.

A brief overview of the three stages is as follows:

Stage 1—Involves standardizing health information into a coded format, tracking, incorporating clinical decision support tools, and reporting quality measures.

Stage 2—Includes all components of Stage 1 plus expands HIT use to improve quality of care, provides for the exchange of information in a structured format, and requires the ability to transmit diagnostic testing information.

Stage 3—Includes components of Stages 1 and 2 plus expands the meaningful use criteria for improved quality of care, safety and efficiency, and includes a means for patients to access their own records and self-help tools.

CMS also clarified that an eligible professional (EP) is a nonhospital-based physician who receives reimbursement from either Medicare or Medicaid and who uses certified EHR technology (CEHR). Each EP is entitled to receive an incentive payment individually, provided he or she meets the meaningful use criteria. This means it is true that each physician in a group practice, regardless of the group's size, is eligible to receive the full incentive payment. EPs must participate in either the Medicare or Medicaid incentive program. Eligible hospitals may participate in both.

Hospital-based eligible professionals (HBEPs) are not eligible for incentive payments through the Medicare program. The reason being HBEPs such as pathologists, anesthesiologists, or emergency department (ED) physicians furnish services covered under the Medicare program during the hospital's reporting period and while using the hospital's facilities and equipment including the hospital's EHRs.

In the proposed rule, EPs who receive incentive payments in the first year have to satisfy Stage 1 requirements in 2011 and 2012. CMS will update the meaningful use criteria in time for the 2013 payment year and, as a result, Stage 2 criteria has to be met in 2013 and 2014 for corresponding incentive payments EP eligibility. Stage 3 criteria needs to be implemented in 2015 for EPs to receive their final incentive payment.

A complete breakdown of each stage of the meaningful use criteria is found in the "Summary of the Proposed Rule for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program (Eligible Professionals only)" found at: www.entnet.org/Practice/loader.cfm?csModule=security/getfile&pageid=77750.

Note: This article is a follow-up to "EHR Primer: Get the Basics," pages 14-15, in the February 2010 *Coding Edge*.

Janice G. Jacobs, CPA, CPC, CCS, ROCC, is a director in Huron Consulting Group's Life Sciences Practice with over 25 years of health care billing, coding, and reimbursement experience. During her career, she has performed documentation, coding, billing, and charge description master (CDM) reviews. She recently served as interim director of coding compliance at a major West Coast academic medical center, where she worked extensively with the Radiation Oncology department. She is a certified public accountant licensed in Pennsylvania, and serves on the National Advisory Board (NAB) of the AAPC.

PROFESSIONAL

Need CEUs

but don't have time to attend a conference or take a class?

With CodingWebU, you can obtain your CEUs

Anywhere - Anytime

CodingWebU.com is the leading provider of online education geared towards Medical Coding and Billing.

Over 75 online courses, books, DVDs, and audio conferences available for CEUs.

Courses start at $30

2009 & 2010 Annual CEU Coding Scenarios are approved by the AAPC for CEUs!
6.5 - 10.5 CEU per course

CodingWebU.com™

Providing Quality Education at Affordable Prices

(484) 433-0495 www.CodingWebU.com

Meet our instructors...

Shannon Smith, Founder/Director/Curriculum Development, CRTT, CPC, CPC-I, CEMC, CMSCS, CPMA (center)
Melody Irvine, Instructor/Curriculum Development CPC, CEMC, CPC-I, CCS-P, CPMA, CMRS (right)
Kevin Townsend, Instructor; CPC, CPMA, CMPE (left)

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS
NAMAS
A subsidiary of DoctorsManagement

Medical Auditor Educational Training:

- Receive expert training and preparation for **AAPC's CPMA™ examination**
- Broaden your career path and job opportunities
- Enhance your credibility with auditing knowledge

Auditing skills taught:

- Compliance; Documentation & Regulatory Guidelines
- Coding Concepts
- Scope & Statistical Methodologies
- Abstraction Ability
- Quality Assurance & Risk Analysis
- Communication of Results & Findings

2 Days—16 CEUs AAPC Approved

Available Now!
Only $149.99

Medical Chart Auditing Study Guide
Preparation for the CPMA™ specialty exam

For more information and class/exam schedules
visit www.NAMAS-Auditing.com or www.AAPC.com
800-635-4040 and ask for Heather Snyder

DOCTORS MANAGEMENT
Leave the business of medicine to us

Are you frustrated and have problems with....

Coding and billing efficiency?
Reimbursement issues and denied claims?
Compliance program updates?
Medicare documentation?
RAC requests?

We can Help!
for quick answers
Call our HOTLINE!
800-635-4040

We also offer -

- **Medical Documentation Audits**
- **Consulting**
- **Customized Onsite Compliance Training**
- **Online instructor-led PMCC courses**

Call for a free consultation with one of our auditing and coding experts to see how we can help you

Since 1956, DoctorsManagement has helped coders, billers, and practice administrators in all specialties touching every state across America.

10401 Kingston Pike
Knoxville, TN 37922
800.635.4040
www.drsmgmt.com