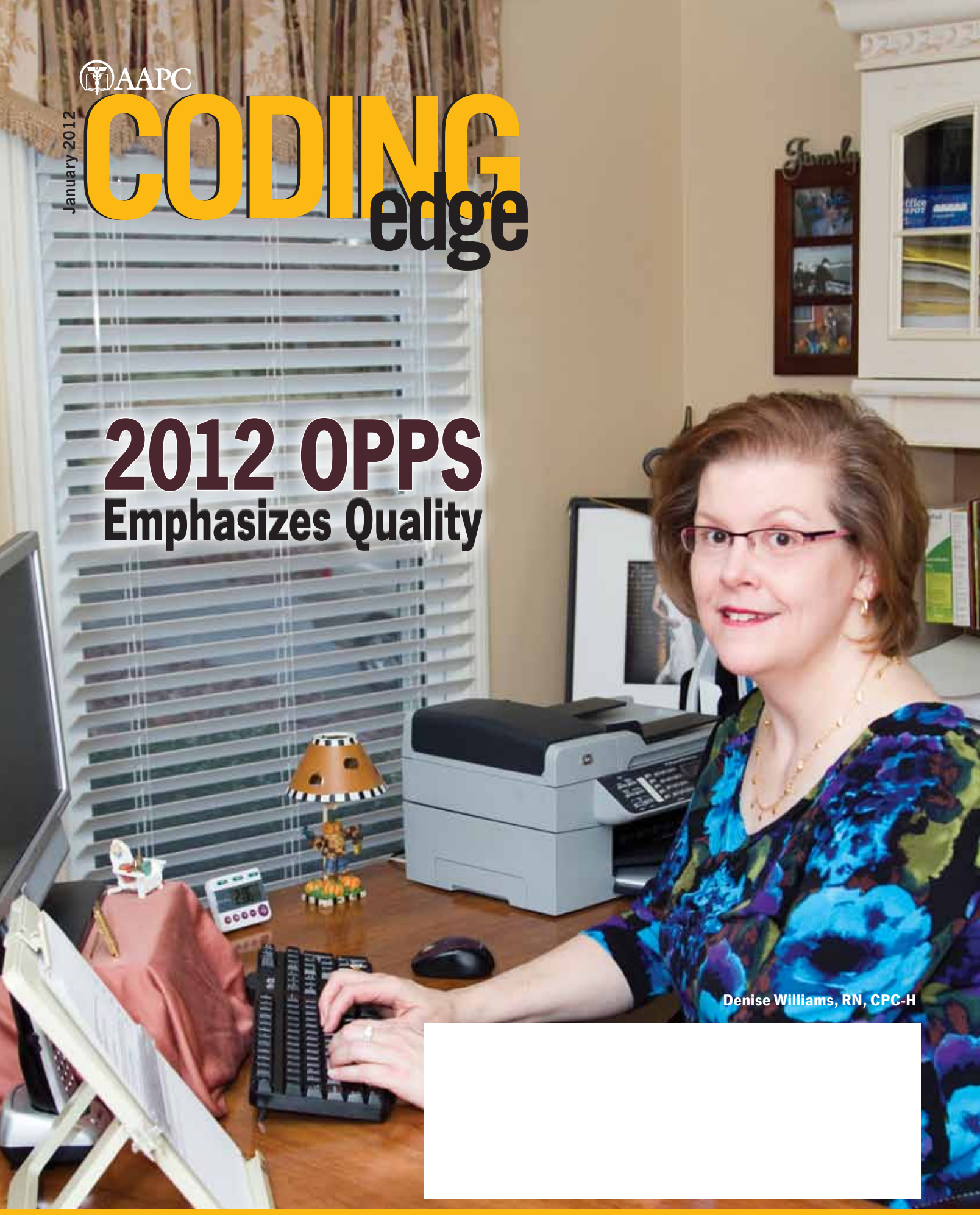
AAPC
January 2012

CODING edge

2012 OPPS
Emphasizes Quality



Denise Williams, RN, CPC-H

Plus: OIG Work Plan • E/M Rules • ICD-10 • Neurosurgery • Colorado Clean-up

"Outstanding! With a physician coder speaking the take away value of this seminar is very high."
Rich Carrillo
LaJolla, CA

"This was definitely the best organized and most comprehensive seminar. Can't say enough about ZHealth Publishing and Dr. Z."
Marge Helgesen
Dallas, TX

"The course is the best I've ever been to."
Shelley Kubczak
Saginaw, MI

"How wonderful to have these complex procedures concisely explained by a physician."
Sarah Mountford
Kansas City, MO

May 1-4
The Boston Park Hotel and Towers
Boston, MA

JOIN US & LEARN

IR, CARDIOLOGY & VASCULAR SURGERY CODING SEMINARS

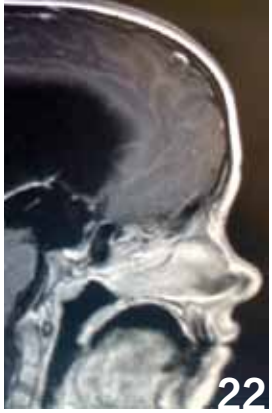
February 21-24

FireSky Resort & Spa

Scottsdale, AZ

ZHealth
PUBLISHING

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



[contents]

Features

On the Cover: **Denise Williams, RN, CPC-H**, of Nashville, Tenn. reports on what the 2012 Outpatient Prospective Payment System (OPPS) final rule has in store for facilities. Cover photo by Penny Rawls Photography (**www.pennyrawlsphotography.com**).

AAPC CODING edge
January 2012

In Every Issue

Special Features

Education

Coming Up

- **Hospital-side OIG**
- **Ergonomics**
- **Same-day E/M**
- **Adjacent Tissue**
- **CPT® 95165**

Serving 110,000 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

AAPC CODING edge
January 2012

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

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

Volume 23 Number 1 January 1, 2012

Coding Edge (ISSN: 1941-5036) is published monthly by AAPC, 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.

contexo | media
a division of Access Intelligence

Thinking about ICD-10?

Get ahead of the 2013 mandatory implementation date with books, code mappers, eLearning and more from Contexo Media.

To learn more about our ICD-10 products, please visit www.codingbooks.com or call 1-800-334-5724 today.

CONTEXO MEDIA
P.O. Box 25128
Salt Lake City, UT 84125-0128

PHONE
800.334.5724

FAX
801.365.0710

ONLINE
www.codingbooks.com

2012 CPMA® Class Schedule

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

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

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

Tuition

NAMAS CPMA® Training
$1025 (Regular Cost)
$895 (AAPC & AHIMA Members)

AAPC Exam
$325

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

2012 Class Date	Class Location
1/10 - 1/11	Knoxville, TN
1/25 - 1/26	New Orleans, LA
2/8 - 2/9	Houston, TX
2/22 - 2/23	Birmingham, AL
3/7 - 3/8	Secaucus, NJ
3/13 - 3/14	Atlanta, GA
3/30 - 3/31	Las Vegas, NV

2012 Class Date	Class Location
4/12 - 4/13	Dallas, TX
4/18 - 4/19	Minneapolis, MN
4/24 - 4/25	Charlotte, NC
5/2 - 5/3	Philadelphia, PA
5/10 - 5/11	Cadillac, MI
5/16 - 5/17	Boston, MA
6/6 - 6/7	Fairfax, VA

* Deposits are non-refundable

NEED CPMA® CEUS?

www.NAMAS-Auditing.com

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

Elimination of "A" Designation

The Apprentice designation is not needed anymore.

The National Advisory Board (NAB) has recommended, and the AAPC leadership team has discussed and agreed, that the Certified Professional Coder-Apprentice (CPC-A®) credential has outlived its usefulness. The objective of the apprentice (A) designation was to show others—primarily prospective employers —an individual had passed the CPC® exam, but did not yet have one or two years of on-the-job experience. Instead, it was too often preventing most CPC-As® from getting interviews for potential jobs and hurting their prospects.

We believe the resumé indicating the experience level of an individual should speak for itself. Whether the individual has great aptitude, a terrific work ethic, good people skills, or any other desirable attribute is often never discovered because an interview is unable to be obtained. While we still believe experience is needed to become a good coder, we think it should be the employer's decision who to hire.

Accordingly, AAPC is accepting comments through Jan. 31, 2012 on the following proposal:

1. Effective July 1, 2012, the CPC-A® credential will no longer be granted. All current CPC-As® would have their "A" removed by doing one of the following:
   a. Getting at least one year of on-the-job experience no later than Dec. 31, 2013 (helpful to those with a job and currently working towards that end), or
   b. Successfully passing a clinical exam consisting of coding 20 operative/office notes
   c. Thus, no current CPC-A® would be "grandfathered" into the CPC® credential.
2. Those taking the CPC® exam after July 1, 2012 will have two ways to get their CPC® credential:
   a. They can have one year of coding experience prior to taking the CPC® exam (proof given at time of exam application), and then pass the CPC® exam, or
   b. They can pass both the current CPC® exam and clinical exam by successfully coding 20 operative/office notes. On-the-job experience after taking the CPC® exam will not be required.
3. It does not matter in which order the two exams are taken; if lacking prior experience, both are required to become a CPC®.
4. The pass rate for the CPC® exam will stay the same and a 90 percent pass rate on the clinical exam will be required. The 90 percent will be determined by correctly coding 18 of the 20 notes (and most will require multiple codes). The clinical exam will not be multiple choice; it will be free form and hand graded.
5. The clinical exam will include a sampling of office visits, surgical notes, evaluation and management (E/M) coding, ancillary services, modifier usage, and diagnosis coding.
6. The clinical exam would be taken at any AAPC proctored exam site. The same five hours and 40 minutes time restriction and code books will be allowed into this exam. If additional resources beyond code books are needed to properly code the notes, that information will be provided as part of the exam.
7. Both exams will be paid for at the same time and the cost for both exams will increase by $35. Applicants may still take each exam twice to pass it. If the examinee has one year experience, then he or she would pay only the CPC® exam price. If one exam is passed after two attempts, but not the other, then the fee for the exam not passed would be paid to re-take it.

Of course, current CPCs® are not affected by this change. As stated above, we would appreciate comments to this important change to our credentialing program through Jan. 31, 2012. You may go to www.aapc.com/cpc-acomment to submit your comment. From those comments we will either proceed ahead, make modifications that strengthen the change, or slow down the change due to legitimate concerns that AAPC has not properly considered.

Your friend,

Reed E. Pew
Chairman and CEO

MEDICAL OFFICE

COMPLIANCE TOOLKIT

The fastest and easiest way to create an effective compliance plan - *in just minutes.*

New for 2012:

- Complete coding and billing compliance
- 2012 coding updates for ICD-9 and HCPCS II
- On-demand, HIPAA webinars to train your entire staff

~~$199~~ **$169**

through 1/31/11

- Complete kit for HIPAA, OSHA, and CLIA compliance
- Create a safe, compliant practice quickly
- Easy-to-follow checklists help you quickly identify compliance deficiencies
- Simple language and clear explanations of current regulations
- Fill-in-the-blank office policies – put into use immediately
- Fully customizable forms (print and electronic) including the most recent HIPAA changes from the HITECH Act

More Than 70 Essential Forms and Templates

- ✓ HIPAA Authorization for Release of PHI
- ✓ Breach Notification Letters
- ✓ Business Associate Agreement
- ✓ Notice of Privacy Practice
- ✓ Security Incident Report
- ✓ *and more*

This 600 page toolkit is a must have for compliant coders, compliance officers, medical code auditors, and physician medical offices.

AAPC
PHYSICIAN SERVICES
Compliant and Profitable Practices

www.aapcps.com/toolkit | 1-866-200-4157

Bring on the New Year

Career-wise, this is my favorite time of year. Not because of the season (I am not a cold weather girl), but because, with the holidays past, resolutions made, and goals for the year set, it's time to get down to business and implement my plans for the new year. I strive to meet the goals and resolutions I set for myself, my continuing education, and my career. For me, digging in and getting down to work is the best part of any plan.

We'll Help You Prepare, Plan, and Move Forward in 2012

If you haven't set your coding, billing, medical administrative, or education goals for the year, it's not too late. Need some help determining what your goals for 2012 should be? Check out **Stephanie Cecchini's, CPC, CEMC, CHISP,** article, "Invest in Yourself for 2012," in December 2011's *Coding Edge*. This article is packed with information, including how to determine what your goals should be in regard to upcoming trends in health care and emerging career paths for coders. She also advises obtaining certain credentials that can boost your career in 2012.

Still not fired up and motivated to set your career goals for 2012? I recommend reading **Lashelle Bolton's, CPC, CPC-H, CPC-I,** article, "Make Your New Year's Code-olution," in this month's edition. In this article, Lashelle has a checklist for making specific, measurable, attainable, relevant, and timely (SMART) career resolutions for both new and experienced coders, encompassing everything from working through removal of apprentice status to facing the challenges of learning the new coding system, ICD-10-CM.

Already accomplished everything included on the Code-olution list? (Hey, it could happen!) There is an abundance of new information included in this month's edition to get every AAPC member off to a great start in 2012. With so much packed into this month's edition of *Coding Edge*, it's hard to know where to start.

Personally, I'm preparing for the year by reading through the articles, "Make the 2012 OIG Work Plan Work for You," "Establish New CPT® Evaluation & Management Rules for 2012," and "2012 Brings a New Code for Brain Death." Two other articles have me intrigued and I'm anxious to read them: "Medical Technology Is Making Humanism a Lost Art" and "Be Leery of Evidence-based Medicine."

Those of us working in outpatient facilities preparing for a new year haven't been forgotten either. Be sure to check out the cover article, "2012 OPPS: Hospitals See Payment Ups and Downs."

Keep Challenging Yourself

If after reading each of these informative and entertaining articles you still haven't found your career resolutions or goals for 2012, I issue you these three challenges:

- Read two to three health care-related articles, (*Coding Edge* or other source) per week.
- Identify a coding, health care, or other issue, topic, or concern which impacts you and your fellow AAPC members. Then, write and submit your findings in an article to *Coding Edge*.
- Find your particular strength in coding, auditing, revenue cycle, practice management, or another area, and share this knowledge with others by presenting at a local chapter or local career college.

Once your career resolution/goals for 2012 have been set, you'll have no trouble focusing on the new year ahead.

Be sure to enjoy the journey, my friends.

Happy New Year!

Best Wishes,

Cynthia L. Stewart

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

President, National Advisory Board

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

Teaching Exception Correction

I noted an error in my article, "I Take Exception with That!" (November 2011, pages 42-45). Specifically, in the "Sample Scenarios" chart (page 43), the third example provides incorrect information regarding modifier application. The article should have stated:

- Apply modifier GC *This service has been performed in part by a resident under the direction of a teaching physician* to charges for new residents A and B.
- Apply modifier GE *This service has been performed by a resident without the presence of a teaching physician* under the primary care exception to charges for old residents C and D.

When I revised the article based on the Center for Medicare & Medicaid Services' (CMS') most recent transmittal, I did not update the modifier section for this scenario.

My apologies for any confusion this may have caused.

Maryann C. Palmeter, CPC, CENTC

Have you heard the news?

We're sad to say we have no "Kudos" to report this month. We want to hear accolades for your coworkers and colleagues!

Please send your Kudos to: **kudos@aapc.com**

By Rhonda Buckholtz, CPC, CPMA, CPCI

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

Having thorough knowledge of anatomy and pathophysiology (A&P) will be crucial when coding diagnoses with ICD-10 because of the expanded clinical detail ICD-10 demands. Test yourself to find out where your A&P skills rank:

A pressure ulcer is a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers are classified by stages.

What is the correct definition of a stage 3 pressure ulcer?

A. Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

B. Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured, serum-filled blister.

C. Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

D. Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

The answer is on page 12.

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

CMS Pays Primary Care Interventions to Reduce Alcohol Misuse

The Centers for Medicare & Medicaid Services (CMS) recently announced it will cover HCPCS Level II code G0442 *Annual alcohol misuse screening, 15 minutes*), consisting of 1 screening session for dates of service on and after Oct. 14, 2011. And, for those beneficiaries (including pregnant women) who screen positive, CMS will cover up to four, brief, face-to-face behavioural counseling intervention sessions (HCPCS code *G0443 Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes*) in a 12 month period.

Alcohol screening/counseling services are payable with another encounter/visit on the same day. This does not apply, however, for the Initial Preventive Physical Examination (IPPE).

For the complete professional billing rules, institutional billing requirements, and policies, see CR 7633 on the CMS website at: www.cms.gov/transmittals/downloads/R2358CP.pdf.

Medicare Adds Obesity Screening and Counseling Coverage

Medicare announced new coverage for preventive services to reduce obesity—adding to its existing portfolio of preventive services available without cost sharing.

Screening for obesity and counseling for eligible patients performed by primary care providers in settings such as physicians' offices may be covered under this new Affordable Care Act benefit.

For complete details, read the national coverage determination at www.cms.gov/medicare-coverage-database.

"Always Therapy" Code Added to 2012 Therapy Code List

Transmittal 2350, released Nov. 18 by CMS, updates the therapy code list for 2012 with one "always therapy" CPT® code: 92618 *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure).*

Therapy cap values for 2012 are $1,880, according to *MLN Matters*® article MM7529 (www.cms.gov/MLNMattersArticles/Downloads/MM7529.pdf).

Telehealth Services Expanded for 2012

CMS is adding four codes for smoking cessation to the list of distant site telehealth services covered under Medicare Part B, effective Jan. 1, 2012 and adding policy instructions to its manuals. The CPT® and HCPCS Level II codes are:

99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes, up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 10 minutes

CMS also is allowing initial inpatient telehealth consultation codes G0425-G0427 to be billed when the place of service is in the emergency department. Note the descriptor changes (emphasized):

G0425	*Telehealth consultation, emergency department or initial inpatient,* typically 30 minutes communicating with the patient via telehealth
G0426	*Telehealth consultation, emergency department or initial inpatient,* typically 50 minutes communicating with the patient via telehealth
G0427	*Telehealth consultation, emergency department or initial inpatient,* typically 70 minutes or more communicating with the patient via telehealth

These codes should be submitted with modifier GQ *Via asynchronous telecommunications systems* or GT *Via interactive audio and video telecommunications systems* to identify the telehealth technology used to provide the service.

Source: CMS Transmittal 2354, CR 7504, issued Nov. 18 (www.cms.gov/transmittals/downloads/R2354CP.pdf).

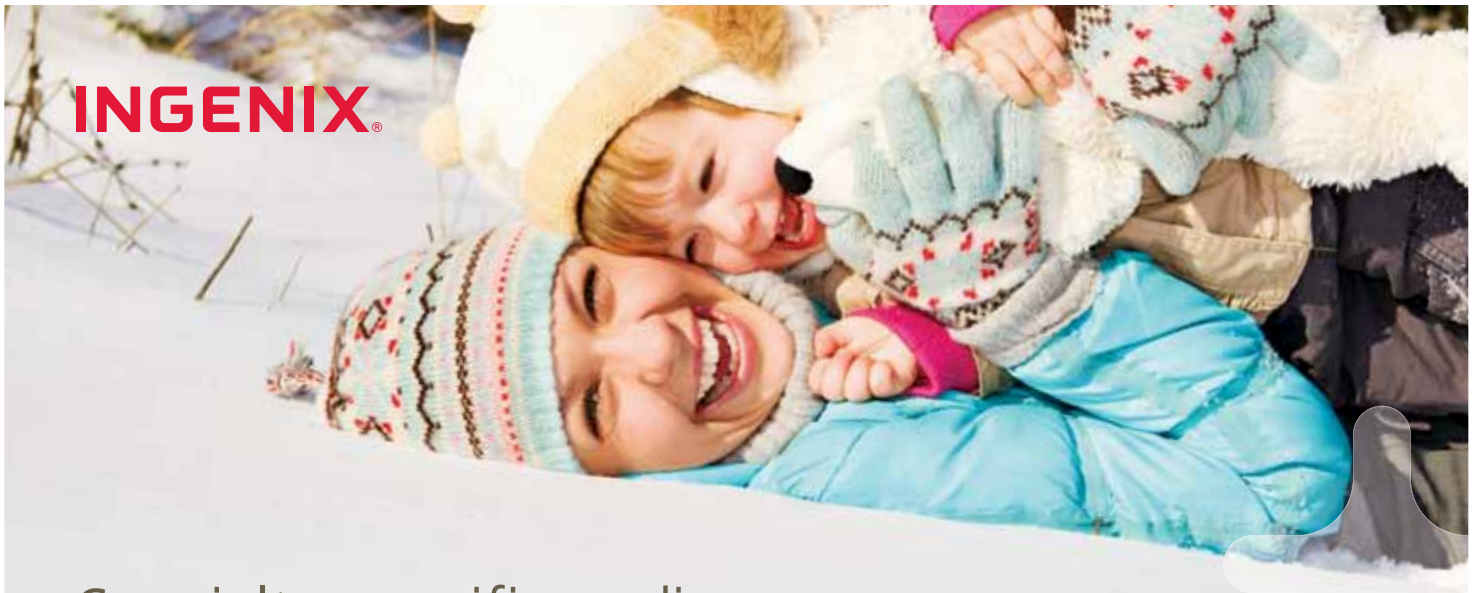
Stay Current on CEUs

AAPC certified members are required to earn Continuing Education Units (CEUs) within their specified renewal period to ensure they stay current on critical industry information and to maintain the integrity of their credential(s). Unfortunately, delinquent submissions of CEUs are trending up at a rapid pace. To counteract this trend, AAPC will implement a $50 CEU extension fee effective April 30, 2012. To avoid this extension fee, make sure to stay current on your CEUs and submit them on time.

For more information on how to obtain your CEUs and the rules for extensions, please see the Continuing Education section of www.aapc.com.

A&P Quiz: The correct answer is C.

INGENIX®



Specialty-specific coding resources

Designed with your unique needs in mind.

We offer a full line of specialty-specific resources for up to 17 different specialties including OB/GYN, pediatrics, OMS, and more, all designed to help you get to the code information you need faster.

Our full line of specialty products include:

Coding Companion® Specialty Guides

Submit accurate claims, faster with the latest ICD-9-CM, HCPCS Level II, and CPT® codes and more

Coding and Payment Guides

Submit accurate claims, faster with the latest ICD-9-CM, HCPCS Level II, and CPT® codes and more

Cross Coders

Code it right the first time with helpful crosswalks that link to the right CPT®, ICD-9-CM, and HCPCS codes

Specialty Desk References

Reduce coding errors by gaining a better understanding of the clinical background of diseases, medical procedures, and anatomy

Fast Finder® Sheets

Quickly access 300 of the most commonly reported codes and descriptions for each specialty with these double-sided, laminated reference sheets

ORDER YOUR 2012 SPECIALTY AND ESSENTIAL RESOURCES TODAY,
SAVE 30 PERCENT, AND GET FREE SHIPPING.

Order online at **www.shopingenix.com/optuminsight**

Call **800.464.3649, option 1**

Remember to mention or enter the source code 143485 to redeem your discount.

OPTUMInsight™

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

By Lashelle Bolton, CPC, CPC-H, CPC-I

Make Your New Year's Code-olution

CODE-OLUTION – The act of coding and of analyzing all things related to coding.

As December rolls out and January heads in, we begin to think about things we'd like to change. Even those of us who are anti-resolutionists find ourselves quietly whispering the things we want to change.

Common resolutions include losing weight, exercising more, getting organized, making better financial decisions, and the list goes on.

These resolutions are beneficial, but let's focus on one very important area in our career—something we all have in common. This year, let's make "code-olutions!"

Examples of code-olutions are:

- ✓ I WILL have the "A" removed from my credential.
- ✓ I WILL learn to code an additional specialty this year.
- ✓ I WILL read a CPT® or ICD-9-CM guideline I haven't read before.
- ✓ I WILL mentor a fellow coder.
- ✓ I WILL attend local chapter meetings.
- ✓ I WILL include new people in my network.
- ✓ I WILL code all reports with the highest integrity.
- ✓ I WILL update all changes that apply to my coding area.
- ✓ I WILL obtain the most current ICD-9, CPT®, and HCPCS Level II code books.
- ✓ I WILL not be afraid of ICD-10.

Whatever your code-olution is this year, make it specific, measurable, attainable, relevant, and timely (SMART).

Involve your fellow chapter members and co-workers. Have fun with your code-olutions! Make a list, commit to it, and give yourself a pat on the back each time you accomplish one of your goals.

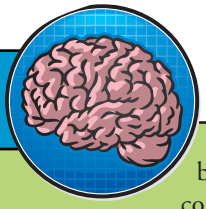
Happy New Year!

Lashelle Bolton, CPC, CPC-H, CPC-I, is on the AAPC Chapter Association (AAPCCA) Board of Directors and is director of reimbursement and business development at Gammarad Practice Management. Ms. Bolton has 20 years of experience serving as a clinical and administrative professional, a certified coder, and coding instructor. She served as president of her chapter in 2009 and is president of the AAPC Upper Saddle River, N.J. local chapter. She has written and presented at various local and national billing and coding seminars.

Even those of us who are anti-resolutionists find ourselves quietly whispering the things we want to change.

By Rahul Srivastava, MD, CPC

2012 Brings a New Code for Brain Death



Brain death is the irreversible end of all brain activity due to total necrosis of cerebral neurons following loss of brain oxygenation. For 2012, ICD-9-CM includes a new, specific code for brain death (348.82 *Brain death*) to clearly identify this patient population for epidemiologic studies.

Today, both legal and medical communities in the United States use "brain death" as a legal definition of death, allowing a person to be declared legally dead even if life support equipment keeps the body's metabolic processes working. Most organ donation for transplantation is done in the setting of brain death. Consent from family members or next-of-kin may be required for organ donation.

The diagnosis of brain death must be rigorous to assure the condition is irreversible. It is important to distinguish between brain death and states that may mimic brain death, such as barbiturate overdose, alcohol intoxication, sedative overdose, hypothermia, hypoglycemia, coma, or chronic vegetative states.

For the first time in 15 years, the American Academy of Neurology (AAN) released new guidelines for determining brain death in adults. The guidelines, published in the June 8 issue of *Neurology*, characterize brain death as no clinical evidence of brain function upon physical examination. This includes no response to pain, no cranial nerve reflexes, no spontaneous respirations, and other signs. Legal criteria to establish brain death vary, but generally require neurological examinations by two independent physicians.

A flat or isoelectric electroencephalogram (EEG) test is not required to certify death, but is considered to have confirmatory value. Alternatively, a radionuclide cerebral blood flow scan that shows complete absence of intracranial blood flow can be used to confirm the diagnosis without performing EEGs.

The National Association of Children's Hospitals and Related Institutions (NACHRI) requested a new unique code for brain death. When brain death is declared early in the course of the hospital stay, life support is removed within a relatively short time. Previously, there was no specific ICD-9-CM code for brain death (the "closest" code was 348.89 *Other conditions of brain*). There is not a corresponding, one-to-one match for 348.82 in ICD-10-CM.

Rahul Srivastava, MD, CPC, has 10+ years of experience in the health care industry. He is member of the International Chapter of AAPC, and works for ICD-10 Transition Solution.

By G.J. Verhovshek, MA, CPC

Establish New CPT® Evaluation & Management Rules for 2012

Successfully apply E/M code modifications in several service categories.

With the release of CPT® 2012, evaluation and management (E/M) guidelines have been updated to clarify the meaning of "new" vs. "established" patients, and code use has been modified for several service categories. Here's what you need to know to apply these changes successfully.

istock.com © Gene Chutka

Three-year Rule Applies to Same Group, Same Subspecialty

Clarifying the definition of new vs. established patients, CPT® now states, "A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years." This is a restatement of the familiar "three-year rule," but is significant in allowing a physician to bill a new patient service (e.g., 99202-99205), even if another physician in the group practice has seen the patient within the past three years—as long as the physicians are of a different specialty/subspecialty.

To make the new/established determination easier, *CPT® 2012 Professional Edition* reintroduces the "Decision Tree for New vs. Established Patients" to the E/M Services Guidelines.

The E/M Services Guidelines further clarify, "Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT® code(s)." A patient might still be new, for instance, if the physician had interpreted test results a month earlier, but had provided no face-to-face services within the previous three years.

Initial Observation Care Can Be Time-based

Many E/M service codes include a reference time: For instance, the descriptor for established outpatient visit code 99214 specifies, "Physicians typically spend 25 minutes face-to-face with the patient and/or family." The reference time allows you to report a service based on time (rather than the key components of history, exam, and medical decision-making (MDM)) when "counseling and/or coordination of care dominates (more than 50 percent) of the physician/patient and/or family encounter," per CPT® instructions.

As an example, the physician spends 30 minutes with an established patient who has been newly diagnosed with type 2 diabetes. During the entire visit, the physician discusses lifestyle changes to help manage the disease and answers questions from the patient and the patient's wife. Based on the key components of history, exam, and MDM, the visit might not support even the lowest-level service. If the physician documents his counseling and the nature of the discussion, however, a level IV visit (99214) could be supported based on time alone.

For 2012, reference times have been added to initial observation care codes, which did not previously include them (See table below for new language in code descriptor).

2012 Added Code Verbiage

CPT®	New Language Added to End of Code Descriptor
99218	Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit
99219	Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit
99220	Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit

Time attributed to the service must be face-to-face with the patient and/or decision makers, or may include unit/floor time in the hos-

CodingWebU.com™

Providing Quality Education at Affordable Prices

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

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

2010 & 2011 Annual CEU Coding Scenarios are Available

2012 Coding Scenarios will be Available Soon!!!

Over 150 Approved CEUs starting from $30

- Anatomy
- Medical Terminology
- Chart Auditing
- RAC
- ICD-9 and ICD-10
- E/M and OB/GYN
- Pain Management Injections
- Emergency Department Coding
- Interventional Radiology
- Burns, Lesions, and Lacerations
- Billing & Reimbursement
- General Surgery Coding
- Specialty Coding
- Modifiers
- Sleep Disorders
- Meaningful Use
- Compliance
- ...and more

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

NEW!! Code Finder and Claim Scrubber $12.50/month

(484) 433-0495 www.CodingWebU.com

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


istock.com © Stigur Karlsson

A patient might still be new, for instance, if the physician had interpreted test results a month earlier, but had provided no face-to-face services within the previous three years.

pital or nursing facility. Adding reference times to these codes also allows for the use of prolonged services in addition to the initial observation care.

Prolonged Services Get an Overhaul

CPT® 2012 adds significant new text directing proper use of prolonged services codes 99354-99357. It defines direct patient contact as "face-to-face," but also counts "additional non face-to-face services on the patient's floor or unit of the hospital or nursing facility during the same session." All codes report the total time duration of care (time does not have to be contiguous), and are in addition to other E/M services that include reference times. A complete list of such services—now including initial observation care services 99218-99220—may be found following the code descriptors.

The term "face-to-face" has been stricken from the code descriptors to allow unit/floor time to count in the inpatient setting; and the codes no longer apply specifically to physicians, but to physicians *and* "other qualified health care professionals" (deleted text has been struck through).

+99354 Prolonged ~~physician~~ service in the office or other outpatient setting requiring direct patient (face to face) contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient evaluation and management service)

+99355 each additional 30 minutes (List separately in addition to code for prolonged ~~physician~~ service)

+99356 Prolonged ~~physician~~ service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient evaluation and management service)

+99357 each additional 30 minutes (List separately in addition to code for prolonged ~~physician~~ service)

Either 99354 or 99356 (depending on the setting) is used to report the first 30-74 minutes of prolonged care (above and beyond the reference time for the primary E/M service). Report only a single unit of 99354 or 99356 per date of service. Codes 99355 and 99357 may be used to report each additional 15-30 minutes of prolonged service beyond the first hour. You may not separately report prolonged services of fewer than 30 minutes.

For example, the physician provides a two-hour counseling/coordination of care session with an established patient just diagnosed with a chronic, but controllable illness. The reference time for the highest-level established outpatient code (99215) is 40 minutes. The physician has provided 80 minutes of service beyond the reference time. If supported by documentation, the physician would report 99215 for the first 40 minutes, 99354 for the next hour, and 99355 for the remaining 20 minutes.

Codes for prolonged services without direct patient contact (99358-99359) have undergone similar revisions; for instance, the codes now apply to physicians and other qualified health care professionals (not just physicians). These codes specifically apply to extensive record review or other time not spent face-to-face with the patient/caregiver or unit/floor time in the hospital or nursing facility. The services need not be provided on the same day as the primary service, and the primary service does not have to include a reference time.

More Services Are Included in Neonatal/Pediatric Critical Care

Lastly, CPT® includes some new language in the guidelines directing use of inpatient neonatal and pediatric critical care (99468-99472) intensive services (99475-99476) codes, and for initial and continuing intensive care services (99477).

Many services/procedures are bundled to critical care, including vascular access and lumbar puncture, to name a few. This year, car seat evaluation (as reported with new codes 94780-94781) has been added to the list of bundled procedures.

Physicians may separately report any services not specifically enumerated by CPT® as included in 99468-99472 and 99475-99476; facilities, however, may separately report even the included services.

New instructions have also been added to clarify billing when a critically ill neonate or pediatric patient is transferred to lower-level care. CPT® specifies "the transferring physician does not report a per day critic care service." Instead, either 99231-99233 (subsequent hospital care) or 99291-99293 (critical care) is reported. The receiving physician reports "subsequent intensive care (99478-99480) or subsequent hospital care (99231-99233), as appropriate based upon the condition of the neonate or child."

Similarly, when a neonate is transferred from intensive care (99477) to a lower-level care, the transferring physician should report subsequent hospital care (99231-99233). If the neonate or infant must be transferred to critical care on a day when initial or subsequent intensive care services have been performed, the transferring physician may report either the critical care (99291-99292) or the intensive care (99477), but not both. The receiving physician may report subsequent inpatient neonatal or pediatric critical care (99469 or 99472).

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

AAPC

MARCH WORKSHOP

HOW TO EFFECTIVELY TEACH E&M CODING TO YOUR DOCTOR IN ONE HOUR

Up to 6 CEUs | Author: Stephanie Cecchini, CHISP, CPC, CEMC

This workshop teaches how to communicate the principals of accurate code selection and documentation requirement using a process that delivers the information in less than an hour and is easy and logical for physicians to grasp and immediately implement. It provides you with specific techniques that translate to improved documentation, accurate code selection and bottom line results.

You'll Learn To:

- Teach physicians how to document and select levels for patient visits.
- Real tips for every day problems physicians have with code-leveling a patient service.
- Learn how to keep a physician out of harm's way during an audit.
- Learn how to get buy-in to reduce under-coding.
- Get answers from a step-by-step description of the CMS 1995 and 1997 Documentation Requirements.
- Newly updated to address concerns with EMRs.

Find a workshop location near you and register today!

www.aapc.com/modifiers
1-800-626-CODE (2633)

Our most popular workshop updated for 2012!

Workshop Features

- *Interactive and hands-on exercises with case studies*
- *4-hours includes presentation and skill-building practice*
- *Comprehensive workbook including presentation slides*
- *Access on-demand recording by the author*

Jillian Harrington, MHA, CPC, CPC-P, CPC-I, CCS-P

Make the 2012 OIG Work Plan Work for You

Follow the OIG's lead to ensure Medicare compliance in your office.

Arguably, there has never been a more tumultuous time to be a coder or a practice manager. You are dealing not only with the daily tasks of a busy and multifaceted physician organization, but also many new and upcoming issues, such as:

- Version 5010 conversion
- ICD-10 implementation
- Electronic health record (EHR) adoption
- Recovery audit contractor (RAC) demands
- Physician Quality Reporting System (PQRS) program requirements

These, and related issues, make daily work interesting, and sometimes complicated.

At the root of all of daily activities is compliance. You must attain and maintain compliance with all federal and state rules and regulations to stay on the right side of the law. At this difficult time in the industry, that can be a tricky thing to do.

Set Forth a Compliance Plan

One way to stay compliant is to have an active auditing and monitoring program as part of a larger compliance program within your practice. In developing your auditing and monitoring plan, a great tool is the Office of Inspector General (OIG) Work Plan. This work plan is released each year in early October, and encompasses all activities the OIG plans to undertake for regularly-scheduled audits and inspections for the following federal fiscal year (not including investigation activity driven by other sources, such as whistleblowers or referrals from the Centers for Medicare & Medicaid Services (CMS)). These regularly-scheduled audits give you a glimpse into issues the OIG is concerned about, and provide you with an opportunity to find and fix issues before the government finds them for you.

Let OIG's Plan Guide You

The OIG released its 2012 Work Plan on Oct. 5, 2011. The section of greatest concern to physician practices is Part I, Medicare Part A and Part B. If your practice sees Medicaid patients, you may be interested in Part III, Medicaid Reviews, as well. If your practice performs clinical research, look at Part V, Public Health Reviews, and specifically the portions regarding the Food and Drug Administration and the National Institutes of Health. These additional sections may be helpful in creating an auditing and monitoring plan specific to your practice.

Several items in the 2012 Work Plan appear for the first time. These include:

Physicians and Other Suppliers

High Cumulative Part B Payments – This OIG intends to review instances where a high amount of cumulative Part B payments are made to an individual physician or supplier, either over a series of payments or for a significant single payment. The OIG will examine the controls in place that ensure payments are not made for services that are not reasonable and necessary, or that do not meet the requirements for payment under the Medicare program.

Physician-Owned Distributors of Spinal Implants – Physician ownership of any device company or distributorship can cause a conflict of interest when a physician-owned distributorship (POD) is selling to hospitals where these physicians provide services or serve on the medical staff. The OIG is looking specifically at PODs of spinal implants and POD usage statistics. Congress has also raised the issue of patient safety. Based on the information in this review, you can expect to see additional investigations of this type in the future, going much further than the spinal implants mentioned in this evaluation.

Physicians

Incident-to Services – Incident-to services is a topic that appears in the work plan regularly, but the OIG is expanding their focus in this area in 2012. The OIG plans to review incident-to services to determine whether there is a higher error

The section of greatest concern to physician practices is Part I, Medicare Part A and Part B—although, if your practice sees Medicaid patients, you may be interested in Part III, Medicaid Reviews, as well.

rate for these services than there is for non-incident-to services. They also are concerned about CMS' ability to monitor services that are billed incident-to a physician's service. When receiving a claim for a service billed incident-to a physician's service, the Medicare contractor has no indication that the service was provided by a non-physician practitioner (NPP) without looking at the documentation. This is one of the many vulnerabilities of incident-to billing under the Medicare program, and why it appears in the work plan so often. Providers must have a good handle on what services they can appropriately bill as incident-to and what they cannot. Include this in your audit plan and review this documentation closely.

Impact of Opting Out of Medicare – Due to the complexities of the Medicare program, as well as the continued threats of dropping reimbursement, some physicians are choosing to opt out of the Medicare program. Alternatively, there is an option for physicians to contract directly with beneficiaries. When contracting directly with a beneficiary, physicians consign to not submit claims to Medicare. This year, the OIG is reviewing how many physicians have opted out of the program, and whether any of these "opt out" physicians are still submitting claims to the program.

Evaluation and Management (E/M) Services

Use of Modifiers During the Global Surgery Period - There are many modifiers that can be used during the global surgery period (e.g., modifiers 24, 25, 59, 79, etc.). These modifiers assist the physician practice in explaining in "code" what the complicated narrative operative or office notes often tell. Unfortunately, the OIG has identified this as an area of abuse. Many providers allegedly place various global surgery modifiers on claims without appropriate documentation to back them up. This review is not focusing on a single specific modifier, nor does the OIG specify which modifiers they will look at. It is a general review of "appropriateness of the use of certain claims modifier codes during the global surgery period," and could include any modifier used during the postoperative period.

Physician-administered Drugs and Biologicals

The OIG is reviewing the reimbursement methodology used for both Medicare Part B and Medicaid plans. Medicare Part B currently uses a derivation of the average sales price to make payment on physician-administered drugs and biologicals. Medicaid generally gives states some latitude in determining their own reimbursement formulas, but all are based on ingredient cost in some way, and manufacturers must provide rebates on Medicaid-covered drugs. This review is a comparison of the two plans, perhaps to determine which is most cost-effective. It is also a good time to look closely at your billing and documentation for drugs and biologicals if you charge for them in your office.

Find Out More

Many more areas will affect physician practices that are not new this year, such as place of service (POS) errors, trends of coding in claims, potentially inappropriate payments, and more. Take this information, as well as other items you pull from the work plan (http://oig.hhs.gov/reports-and-publications/workplan/index.asp#current), and build your auditing and monitoring plan around it. Examine the areas the OIG is reviewing, and learn more about the level of compliance in your organization. Use the OIG's map to compliance to build one of your own, and stay on track during this complex time in our industry.

Next month, we'll examine the hospital side of the OIG 2012 Work Plan.

Jillian Harrington, MHA, CPC, CPC-P, CPC-I, CCS-P, serves as a clinical technical editor for Ingenix/OptumInsight, and has nearly 20 years of experience in the health care industry. She is a former chief compliance officer and chief privacy official. She teaches CPT® coding as an approved AAPC instructor and was a member of AAPC's ICD-10 curriculum development team. She holds a bachelor's degree in health care administration from Empire State College and a master's degree in health systems administration from the Rochester Institute of Technology (RIT).

By Samer K. Elbabaa, MD, FAANS, and G. J. Verhovshek, MA, CPC

Code the Complexities of Pediatric Intracranial Endoscopies

Two points can help code these technologically advancing neurosurgery procedures.

Coding for intracranial neuroendoscopy is easier if you remember just two important points:

1. With the exception of endoscopic assist for placement or replacement of ventricular catheter (which is an add-on service), all neuroendoscopic services are coded as "stand-alone" procedures.
2. The National Correct Coding Initiative (NCCI) bundles "access" procedures, such as twist drill or burr holes, to neuroendoscopic procedures.

Neuoroendoscopy is a minimally invasive surgery, which when applied to intracranial surgery has resulted in positive outcomes for patients with specific pathologies. The goal of minimally invasive neurosurgical procedures is to reduce pain and blood loss, shorten recovery time, and reduce scarring.

Use Add-on and Primary Codes for ETV

Applications for the neuroendoscope include a wide range of procedures. Of these, endoscopic third ventriculostomy (ETV) is the most frequently performed. ETV has become a standard treatment for selected patients with symptomatic obstructive hydrocephalus.

Hydrocephalus is caused by disturbance of formation, flow, or absorption of cerebrospinal fluid (CSF), which leads to a buildup of fluid in the central nervous system (CNS). Incidence of congenital hydrocephalus (ICD-9 742.3x; or, with spina bifida, 741.0x) is three per 1,000 live births. To divert excess CSF, the surgeon places an intracranial shunt. A ventricular catheter in the brain is routed subcutaneously to another body area (for instance, the abdominal cavity) to allow the fluid to drain and be absorbed. A one-way, pressure-controlled valve regulates the flow of CSF through the catheter.

Primary coding for intracranial shunt placement is reported using CPT® codes 62220-62230, depending on the precise location of the shunt/drain and method of insertion. Primary coding for ETV, specifically, is reported using 62200 *Ventriculocisternostomy, third ventricle* or 62201 *Ventriculocisternostomy, third ventricle; stereotactic, neuroendoscopic method if using stereotactic (navigational) guidance*.

When any of the above procedures are performed using the neuroendoscope, report +62160 *Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage (List separately in addition to code for primary procedure)* in addition to the primary code.

Per CPT® instruction, add-on code 62160 also may be reported with 61107 *Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device* and 61210 *Burr hole(s); for implanting ventricular catheter, reservoir, EEG electrode(s), pressure recording device, or other cerebral monitoring device (separate procedure)*, as well as 62258 *Removal of complete cerebrospinal fluid shunt system; with replacement by similar or other shunt at same operation* for shunt removal and replacement.

Treat All Other Neuroendoscopes as "Primary" Procedures

Intracranial neuroendoscopy may be used for procedures other than ETV, such as biopsy or excision of intra-ventricular brain tumors, trans-sphenoidal excision of pituitary tumor, fenestration of colloid cyst, craniosynostosis, and more. Applicable CPT® codes include:

62161 Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)

62162 with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage

62163 with retrieval of foreign body

62164 with excision of brain tumor, including placement of external ventricular catheter for drainage

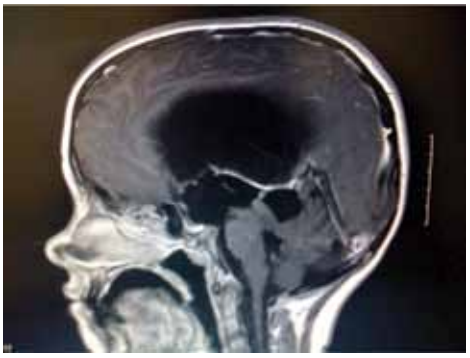
62165 with excision of pituitary tumor, transnasal or transsphenoidal approach

Each of these codes should be reported as a "definitive" procedure, rather than an extra step. In other words, never report an endoscopy code in addition to the code that describes the identical "open" procedure. For example, you would report endoscopic fenestration of an intracranial cyst with 62162 alone—not in addition to the open code (61516 *Craniectomy, trephination, bone flap craniotomy; for excision or fenestration of cyst, supratentorial*).

On occasion, a surgeon may have to "convert" from an endoscopic procedure to an open procedure. When this occurs, report only the successful (open) procedure. Never report an endoscopic procedure and its open equivalent together.

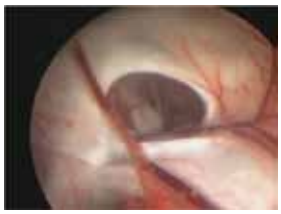
Be Aware of Bundles

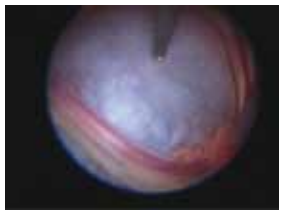
NCCI bundles access procedures 61105-61253, which describe twist drill, burr hole(s), or trephine, into neuroendoscopic proce-



Endoscopic shunt placement surgery for hydrocephalitis.

The goal of minimally invasive neurosurgical procedures is to reduce pain and blood loss, shorten recovery time, and reduce scarring.





dures 62161-62165. As well, neuroendoscopic procedures may be mutually exclusive of other intracranial procedures. For example, NCCI lists 62164 as mutually exclusive of skull base surgery codes (61601, 61606-61608, and 61615-61616) and other procedures. Be sure to check NCCI thoroughly before billing neuroendoscopy with other intracranial procedures.

CPT® hasn't added new intracranial neuroendoscopy codes since 2003, but coders are likely to see more procedures in the years ahead. Technological advances in endoscopic instrumentation will help surgeons to add new indications and approaches that are less traumatic compared to conventional open neurosurgery, and to improve visualization of pathologies.

Samer K. Elbabaa, MD, FAANS, is director of pediatric neurosurgery and assistant professor of neurosurgery at Saint Louis University School of Medicine. His clinical practice focuses on minimally invasive neurosurgery, pediatric brain and spinal tumors, complex spinal instrumentation, cranio-cervical junction anomalies, neuro-endoscopy, and cerebrovascular surgery. Elbabaa's research focuses on advancing endoscopic techniques in cranial and spinal neurosurgery.

By Brad Ericson, MPC, CPC, CPCO

ICD-10 Training: Get Help with A&P and Code Set

Proper training will prepare AAPC professionals to become leaders in ICD-10 adoption.

ICD-10's implementation on Oct. 1, 2013 will change everything from the way health care providers document services to the way codes are selected, reported, and reimbursed. It forces medical staff to see computers as partners rather than simple tools. The advent of ICD-10 will homogenize practices, requiring all who come in contact with patients and their records to adapt. Yet, it will be coders who set the keystone for success.

Preparation Is Key

Imagine how you'd prepare for an elderly relative's move to your house. You'd be anxious, for sure, but preparation would override that as you made decisions about the physical changes the house requires and alterations to your routines. The new member of your household would bring stress, but housing her must be done. Ultimately, the experience would make you grow, and maybe even a newfound appreciation would form.

That's why AAPC is putting so much time into helping you prepare. "ICD-10 is not just about coding," **Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC,** AAPC's vice president of ICD-10 education, recently told attendees at the annual meeting of the American Academy of Otolaryngologists. "It changes everything about your practice. If you don't make the transition to ICD-10 on time, you won't get paid. It's that simple."

ICD-10, with 78,797 new diagnostic codes, may seem overwhelming, but its elegance is impressive. For example, ICD-10 codes for diabetes are more specific, helping to identify the care needed. Ilio-sacral joint problems, previously reported as unspecified lower back pain, now can be specifically coded and care better tracked.

New specificity found in the codes will help make documentation for pay-for-performance and quality tracking programs much easier, Buckholtz says. Every form, procedure, policy, contract, or program will be affected as each of these is tied to diagnostic coding.

All Eyes on Coders

Americans like to do things bigger and better. It's no wonder, then, that even though we are one of the last countries to adopt ICD-10, our clinically modified version expands 79,000 codes laterally to seven characters rather than the usual five used by other countries. Our ICD-10 is big. It means physicians and other health care professionals must provide detailed documentation so you can code to the greatest specificity.

The expected advantages of electronic health records (EHRs) aside, all eyes will turn to coders to make sense of ICD-10-CM and ICD-10-PCS, Buckholtz tells *Coding Edge*.

Central to success is a better understanding of anatomy and pathophysiology (A&P), Buckholtz says, cautioning even the savviest coders to strengthen their knowledge of A&P. The specificity of ICD-10 codes is based on a precise identification of body sites and function. Not only will you need to know that, but you will also need to help your provider understand why detailed documentation is necessary, she says.

AAPC provides a number of resources—Web-based, live, and printed—to help you lead your practice into this new way of managing the data and revenue of patient care. You can access information on ICD-10 implementation, 5010 electronic transaction standards, and other coding facets through a number of avenues.

Every form, procedure, policy, contract, or program will be affected as each of these is tied to diagnostic coding.

ICD-10 is not just about coding ... It changes everything about your practice.

For the last two years and through this August, AAPC has been helping practices, payers, and facilities prepare for ICD-10 implementation. Beginning in September 2012, code set training will be everyone's focus.

Training Steps to 2013

Buckholtz outlines a five-step process to ICD-10 implementation, which can be found at www.aapc.com on the ICD-10 tab. Here you will find explanations for the various training tools and a tracker to help you gauge your preparedness and get your practice ready. AAPC also offers to members a free ICD-9 to ICD-10 code conversion tool based on the Centers for Medicare & Medicaid Services' (CMS') general equivalence mappings (GEMs) files. Simply enter an ICD-9 code to see the ICD-10 code(s) equivalent.

ICD-10 Implementation Training – AAPC offers a two-day boot camp or on-site training for larger organizations, outlining all the steps and resources needed to switch to ICD-10-CM and ICD-10-PCS. These boot camps are held all over the country and attendees leave armed to prepare.

A&P – This 14-hour, online, advanced training will strengthen your A&P knowledge so you can feel confident in your ICD-10 code selection. This will help you earn up to 14 CEUs.

Clinical Requirements in ICD-10 – This online program will help your provider fine-tune documentation to meet the rigid standards ICD-10 will demand.

ICD-10-CM General Code Set Training – This code set and guidelines training begins in September this year with online or boot camp training. Hands-on exercise will help attendees feel more confident about the upcoming change as they become familiar with the new system. Training will be offered as workshops and online. Conferences in 2013 will include general code training.

ICD-10-CM Specialty Code Set Training – Beginning January 2013, specialty code set training will help coders see the impact ICD-10-CM will have in a particular setting. ICD-10 will, for example, affect cardiology differently from pediatrics.

Online Proficiency Prep Tool – Available in September, this online tool will help coders prepare for ICD-10 with case studies, practical exercises, and tips for passing their proficiency assessment.

Proficiency Assessment – Prove ICD-10 expertise to colleagues and providers by taking this 75-question exam before Sept. 30, 2014. Certified coders should complete this exam to maintain their status as elite coders.

More ICD-10 Resources

AAPC already offers and is developing several tools to make the transition easier.

ICD-10 Fast Forward – These inexpensive, laminated sheets include crosswalks from ICD-9-CM to ICD-10-CM for the top 50 diagnoses for 15 specialties. Learn of frequently-used codes in your specialty that will change, and use the cards to help develop new superbills and train others in your practice.

ICD-10 Code Books – AAPC will offer the final code set with guidelines you can use as a learning and documentation assessment tool beginning early 2012.

Local Chapter Training – Local chapters have two options: Easily accessed chapters can request a visit from a National Advisory Board (NAB) member or one of the AAPC Chapter Association (AAPCCA) Board of Directors members. For those where travel is difficult or who can't wait, download an ICD-10-CM and ICD-10-PCS presentation from the local chapter page at www.aapc.com.

Webinars and Workshops – ICD-10-CM/PCS is part of AAPC's regular educational fare. Take advantage of on-demand webinars or the latest in on-demand workshops, such as November's "ICD-10, What You Need to Know Now!" by **Kim Reid, CPC, CPMA, CPC-I, CEMC**.

Free resources and costs for training can be found on www.aapc.com. According to Buckholtz, "AAPC is trying to provide as much I-10 support and training in the most affordable, effective, and accessible ways possible. We want our members to be the leaders in I-10 adoption at their workplaces because nobody can code like an AAPC member."

Brad Ericson, MPC, CPC, COSC,
is director of publishing and warehouse at AAPC.

ICD-10

Code Set Training for Coders

Core Training

General Code Set Training | *Beginning Sept.* | 16 CEUs | **$595***

- Learn to code for ICD-10 and prepare for the ICD-10 Proficiency Assessment.
- Three Options: Boot camp, online, or at one of eight 2013 ICD-10 conferences.

Supplemental Training

Anatomy & Pathophysiology | *Available Now* | 14 CEUs | **$149.95***

- Get a refresher on A&P and prepare for the increased clinical requirements of ICD-10.
- 14 online modules with workbook and quizzes.

Proficiency Assessment Workbook | *Available Sept.* | **$39.95***

- Improve your preparedness for the ICD-10 Proficiency Assessment.
- Full of case studies, practical exercises, and tips for passing.

Specialty Code Set Training | *Available Jan. 2013* | 4-8 CEUs | **$150-295***

- Multi-specialty or single-specialty code set training with hands-on exercises.
- 4- to 8-hour online courses (view list of specialties at www.aapc.com/icd-10)

Complete Training for Under $1,000

Bundle with A&P

- General Code Set Training
- Specialty Code Set Training
- Proficiency Workbook
- Proficiency Assessment
- ICD-10 Codebook
- Anatomy & Pathophysiology

As low as **$895***

Bundle without A&P

- General Code Set Training
- Specialty Code Set Training
- Proficiency Workbook
- Proficiency Assessment
- ICD-10 Codebook

As low as **$745***

ICD-10 Conferences

- General Code Set Training
- Specialty Code Set Training
- Proficiency Workbook
- Proficiency Assessment
- ICD-10 Codebook

8 Available in 2013 for **$795***

ICD-10

Code Set Training for Physicians

Core Training

Clinical Requirements of ICD-10 | *Available Aug.* | 3 CMEs | $395*

- Learn to document and code for ICD-10 in your specialty.
- Taught by a physician and from a provider's perspective.
- Review ICD-10-CM requirements, case examples, and top 50 codes (by specialty).
- 3-hour online course (per specialty).

Clinical Documentation Evaluation | *Available Now* | $395*

- Validate your current documentation in preparation for ICD-10.
- Identify the deficiencies and training needed to improve.
- Avoid denied or un-billable claims and reduce the risk of interruption in revenue.
- Includes 10 pre-training and 10 post-training chart note audits.

Complete Training for Under $700

Clinical Bundle

- Clinical Requirments of ICD-10
- Clinical Documentation Evaluation
- ICD-9 to ICD-10 Crosswalk (for your specialty)

As low as **$695***

ICD-10
Will Change Everything

AAPC
Credentialing the Business Side of Medicine

* Prices guarateed through Dec 31, 2012

To learn more about our training and free resources to prepare for ICD-10, visit us at:

www.aapc.com/icd10

By Denise Williams, RN, CPC-H

2012 OPPS:

Hospitals See Payment Ups and Downs

Overall CMS estimates an increase with an emphasis on quality reporting.

In the 2012 Outpatient Prospective Payment System (OPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) bases payments on claims data submitted by hospital providers during 2010. CMS estimates that payments under the OPPS will increase overall by 1.9 percent; however, there are other factors at play.

Although the rural adjustment (7.1 percent) will continue for rural sole community hospitals (SCHs), which includes essential access community hospitals (EACHs), the transitional outpatient payments (TOPs) will expire for services provided on or after Jan. 1, 2012 for both rural hospitals with 100 or fewer beds that are not an SCH, and SCHs (including EACHs) in accordance with section 108 of the Medicare and Medicaid Extenders Act of 2010 (MMEA).

Dedicated cancer centers can expect an estimated 9 percent reimbursement increase this year; the money for this adjustment will come from OPPS payment to other facilities due to the budget neutrality requirement under the OPPS. Overall, some hospitals will realize a modest increase in payment while others will experience a modest decrease in payment.

istock.com © Diego Ontivero

You can download the CMS display copy of the rule and all preamble tables and addenda at: www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp. Select CMS-1525-FC to download the "Final Changes to the Hospital Outpatient Prospective Payment System and CY 2012 Payment Rates" final rule.

Composite APCs Remain the Same

No changes were made to existing composite ambulatory payment classifications (APCs), nor were any new composite APCs created for 2012.

In the proposed rule, CMS considered a new composite for cardiac resynchronization therapy-defibrillator (CRT-D) when CPT® codes +33225 *Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to code for primary procedure)* and 33249 *Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator* were performed on the same day. CMS also proposed to provide payment for this composite at either the APC payment or the payment for Medicare severity diagnosis-related group (MS-DRG) 227, whichever was lower. CMS stated that reimbursement for this service under an APC composite payment should not be more than was paid under the Inpatient Prospective Payment System (IPPS) because the outpatient procedure would "by definition, include fewer items and services than the corresponding MS-DRG payment." Although this proposal was not finalized, the status indicator for CPT® +33225 was changed from T to Q3 in the final rule. This means that when +33225 and 33249 are reported on the same claim in 2012, the I/OCE will composite the payment for both +33225 and 33249 into a single payment under APC 0108.

CMS notes that they plan to continue down the path of creating larger payment bundles and expanding the number of composite APCs, and reiterates, "we will continue our efforts to model other composite structures for a possible new extended assessment and management composite structure for CY 2013."

CMS notes that they plan to continue down the path of creating larger payment bundles and expanding the number of composite APCs ...

Outlier Fixed-dollar Thresholds Updated

CMS annually updates the formula for calculating outlier payments. Consistent with prior years, for 2012 an outlier payment will be triggered when costs for providing a service or procedure exceed both:

- 1.75 times the APC payment amount; and
- the APC payment plus the $1,900 fixed-dollar threshold (decreased $125 from 2011).

No changes were made to the outlier reconciliation policy for outpatient services provided, based on cost reporting periods beginning in 2009.

Pass-through Payment Changes

Three devices are eligible for pass-through payment in 2012. HCPCS Level II code C1749 *Endoscope, retrograde imaging/illumination colonoscope device (implantable)* will continue with pass-through status for 2012. The two additional devices are C1830 *Powered bone marrow biopsy needle* and C1840 *Lens, intraocular (telescopic)*. Edits will continue for device/procedure reporting and radiopharmaceutical/nuclear medicine procedures.

Reporting of modifiers FB *Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)* and FC *Partial credit received for replaced device* continues to be mandated by CMS, and the appropriate reporting is being reviewed by the Office of Inspector General (OIG). These modifiers indicate that a device was received at no cost or at a discounted cost from the manufacturer and triggers a reduced APC payment. The APCs for which these modifiers apply are listed in Tables 30 and 31 of the OPPS final rule.

Pass-through status for 19 drugs and biologicals expired Dec. 31, 2011. These are listed in Table 32 of the final rule. The cost of 14 of these drugs is above the packaging threshold, which is $75 for 2012, and separate payment will continue. Payment for separately-payable drugs without pass-through status will decrease for 2012 to average sale price (ASP) plus 4 percent.

For the 38 drugs and biologicals with pass-through status for 2012, payment is ASP plus 6 percent. These drugs are listed in Table 33. There are HCPCS Level II code changes for several of these drugs; for example, C9270 is replaced by J1557 *Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg* beginning Jan. 1, 2012.

Number of Inpatient-only Procedures Continues to Shrink

For 2012, CMS removed 10 procedures from the inpatient-only list, which allows hospitals to be reimbursed when these procedures are performed on an outpatient basis. The "Inpatient Only" list specifies procedures not reimbursable under the OPPS because they are typically provided in an inpatient setting due to the invasive nature of the procedure; the need for at least 24 hours of post-procedure monitoring before the patient can be safely discharged; or the underlying physical condition of the beneficiary. These procedures, their corresponding CPT® codes, and APC assignments are listed in Table 46.

Direct Supervision for Outpatient Therapeutic Services

In 2011, CMS delayed enforcement of direct supervision for therapeutic services provided in critical access hospitals (CAHs) and small rural hospitals with 100 beds or fewer. In the 2012 OPPS final rule, CMS extended this non-enforcement period through 2012.

In the 2011 final rule, CMS proposed to create a committee that would consider changing the level of supervision required for therapeutic procedures performed in a hospital outpatient department. The APC Advisory Panel has been given the accountability to independently review and assess the appropriate supervision level for hospital outpatient therapeutic procedures. For the supervision level to be changed, a therapeutic service must be presented to the panel for review and consideration. Because these decisions impact CAHs and rural hospitals, CMS will add four representatives (two for CAHs and two for rural) to the panel to represent these entities during the supervision consideration and decision process. The following criteria will be used to evaluate whether a change in supervision level is warranted:

1. The complexity of the service
2. The acuity of the patients receiving the service
3. The probability of an adverse or unexpected event occurring
4. The expectation of rapid clinical changes occurring during the therapeutic service

CMS policy of reducing payment to hospitals that fail to meet quality reporting requirements continues at 2 percent for 2012.

CMS will solicit comments via a 30-day sub-regulatory process. CMS states, "We believe that it would be out of the APC Panel's scope of activities for it to deliberate on the underlying definitions of direct, general or personal supervision, or for it to consider recommending yet another type of supervision based on a supervisory practitioner's location."

Hospital Quality Reporting Program

CMS policy of reducing payment to hospitals that fail to meet quality reporting requirements continues at 2 percent for 2012. This reduction extends to the beneficiary and secondary payer payments, as well. CMS will again use a separate conversion factor to apply these reduced payments. Details regarding revisions to proposed measures, measures not finalized, changes in dates for data collection and submission, and other details related to reporting of quality data are noted in section XIV - Hospital Outpatient Quality Reporting Program Updates and ASC Quality Reporting Program, beginning on page 1,069 in the final rule.

Additional Notable Changes

In the 2012 Medicare Physician Fee Schedule final rule (CMS-1524-FC, found at www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp), CMS reversed its 2011 decision requiring physician or non-physician authentication on requisitions for clinical diagnostic laboratory tests paid under the lab fee schedule, but noted that independent laboratory service providers may develop their own compliance procedures, requiring a physician's or non-physician practitioner's (NPP's) signature on the requisition to be certain that a service is provided in response to a valid order. CMS stated:

"The requirement that the treating physician or NPP must document the ordering of the test remains, as does our longstanding policy that requires orders, including those for clinical diagnostic laboratory tests, to be signed by the ordering physician or NPP. We believe that all parties share in the responsibility of ensuring that Medicare services are provided only in accordance with all applicable statutes and regulations, such as the requirement for a physician or NPP order."

In 2011, CMS initiated an End-Stage Renal Disease (ESRD) Prospective Payment System and related consolidated billing edits. Under the ESRD PPS, certain laboratory tests related to ESRD management are included in the payment to the ESRD facility and are not reimbursable to other providers. Edits were created to insure that payment for these tests was not made to providers other than the ESRD facility. CMS created modifier AY *Item or service furnished to an ESRD patient that is not for the treatment of ESRD* to indicate tests were not related to management of ESRD; however, CMS did not anticipate the operational burden related to application of this modifier for services provided in the emergency department (ED). In the 2012 update (CMS-1557-F, located at www.cms.gov/ESRDPayment/PAY/list.asp#TopOfPage), CMS notes that lab tests performed in the ED will be excluded from the consolidated billing edits beginning in January 2012. Implementation details can be found in CMS Transmittal 2281 (www.cms.gov/Transmittals/downloads/R2281CP.pdf).

Denise Williams, RN, CPC-H, is the vice president of revenue integrity services for Health Revenue Assurance Associates, Inc. She has been involved with APCs since their initiation. She has worked as corporate chargemaster manager for two health care systems and is heavily involved in compliance and coding/billing edits and issues.

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

It's a new year

This year, take advantage of the Medicare Learning Network®, your source for official Medicare Program coding information.

http://go.cms.gov/coding-edge

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

See you in Las Vegas!

AAPC National Conference April 1-4, in Las Vegas

By Jeremy Reimer, CPC

Be Leery of Coding Errors in Evidence-based Medicine

Cookbook medicine may be a recipe for coding disaster.

Recently, I was asked to review the medical records of two patients involved in a motor vehicle accident. The patients were taken to a hospital practicing evidence-based medicine (EBM).

Dr. David Sackett, an early proponent of EBM, has defined it as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." The practice is also commonly referred to as "cookbook medicine" because it follows a "recipe" for treating patients. Those in favor of EBM claim it promotes greater uniformity and consistency of treatment. For example, the facility in our example states in its *Trauma Handbook*:

"The term 'cookbook medicine' is much maligned. However, few chefs would attempt a complex dish without a recipe to guide them, and few musicians would attempt a complex piece without written music to direct them. These guidelines are not meant to mandate rigid adherence, but are meant to provide a framework, based on extensive experience and knowledge."

Opponents counter that EBM results in a lower standard of safety by deskilling practitioners: Instead of using clinical judgment, practitioners are encouraged to follow protocols that treat all patients as essentially interchangeable.

istock.com © Daniel Loiselle

Dangers of Cookbook Medicine

Whatever the clinical merits of EBM, its practice can create a recipe for coding disaster if the concepts of "reasonable and necessary" and "medical necessity" are overlooked in favor of "standard protocol." The medical records I was asked to review provide a good example.

Here are the facts of the case: Following an auto accident, the driver was complaining of chest pain as a result of the seat belt tightening, and the passenger had a laceration above his left eye, from the eyebrow to the hairline.

Emergency medical technicians (EMTs) use a severity scale that ranges from ALPHA (least severe) to ECHO (most severe). An example of Code ECHO would be a patient whose condition is life threatening, and requires immediate resuscitation and life sustaining measures. The EMTs arrived on scene and relayed a Code "ECHO" to the hospital to describe both patients.

Per the EMT's own incident report, the use of a Code ECHO was not warranted in this case. The patient with the head laceration was alert, had 100 percent oxygen saturation, a Glasgow Coma Scale score of 15 (least critical), controlled bleeding, and good vision. The records for the driver were nearly identical.

Just Following Protocol ...

But because the EMTs notified the hospital that they were transporting two Code ECHO patients, the hospital followed its protocol of "cookbook medicine" (their own term), which provided numerous predetermined treatments based on the initial EMT evaluation. The notes from each of the procedures performed at the hospital listed the "Reason for exam/procedure" as "trauma." The ICD-9-CM codes were different for every procedure performed. In fact, there were no fewer than 13 different ICD-9-CM codes for each patient.

Here are some of the ICD-9 codes used for the various tests performed for these patients:

- **Abdominal Computed Tomography (CT) Scan:** 959.19 *Other injury of other sites of trunk*
- **Pelvic CT Scan:** 867.8 *Injury to unspecified pelvic organ without open wound into cavity*
- **Chest X-ray:** 786.09 *Other dyspnea and respiratory abnormality*
- **Head CT Scan:** 854.00 *Intracranial injury of other and unspecified nature without mention of open intracranial wound with unspecified state of consciousness*

The last ICD-9-CM code is particularly noteworthy for several reasons. First, the patient was never unconscious, so "unspecified consciousness" is incorrect. Second, "intracranial injury" is used to describe traumatic brain injury,

> From a coding perspective, it is improper for a facility to perform a pre-planned list of procedures on "trauma" patients, regardless of actual need or medical necessity.

for which there was no evidence. Lastly, this was a patient with a cut that required fewer than 10 stitches, and did not even meet the criteria of a "complicated" wound by ICD-9-CM standards (e.g., delayed healing, delayed treatment, foreign body, or infection). A more appropriate code would have been 873.42 *Other open wound of forehead (eyebrow)*. But, that code would not have justified a head CT scan, would it?

From a coding perspective, it is improper for a facility to perform a pre-planned list of procedures on "trauma" patients, regardless of actual need or medical necessity. It is also improper to use vague or exaggerated diagnosis codes to justify CT scans and other diagnostic procedures when the objective findings, as well as the patient's subjective complaints, do not support the use of those codes.

Medical procedures are supposed to be performed based on the diagnoses rendered. The scenario described above reverses this notion, putting "the cart before the horse," so to speak.

What Can a Coder Do in This Situation?

Coders should work with compliance officers to make sure they agree on the specific documentation needed to support the diagnosis codes used for each procedure. Coders should also consult with physicians for clarification when they encounter conflicting or ambiguous information in the chart. As coders, we have an ethical obligation to assess the documentation, and to ensure it is adequate and appropriate to support the selected diagnosis and procedure codes.

Jeremy Reimer, CPC, is president of Medical Coding Litigation Services, which provides medical coding and billing review to insurance carriers, legal counsel, and companies involved in personal injury litigation. He is vice-president of AAPC's Brandon, Fla. chapter, a member of the American College of Forensic Examiners, and a frequent lecturer on medical coding and billing fraud. Mr. Reimer can be reached at: jreimer@mcls.co.

By Lynda Vining, CPC

Key Words Help Pinpoint Tubal Sterilization Coding

When it comes to these procedure codes, look to technique, approach, method, and timing.

When coding tubal sterilization procedures, it's all about the technique, approach, method, and timing. The code descriptions hold the answers, helping you select the correct CPT® code. For example:

- Tubal sterilization may be accomplished by several techniques, including incisional or via hysteroscope or laparoscope.
- Tubal sterilization may be accomplished by several methods such as fulguration, ligation, occlusion, or transection.
- Tubal sterilization can be performed by abdominal, suprapubic, transabdominal, transcervical, or vaginal approach (the approach is not coded separately, but may be a specific component of the procedure).
- Tubal sterilization may be performed at the time of a cesarean delivery or other intra-abdominal surgery, during the same hospitalization as the delivery or other intra-abdominal surgery, but on a different day, or after the hospitalization in which the delivery or other surgery occurred.

istock.com/©Medical Art Inc.

CPT® Codes for Tubal Sterilization

58565 Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants

With this procedure, the physician performs a hysteroscopy with bilateral fallopian tube cannulation and placement of permanent implants, which occlude the fallopian tubes. The physician advances the hysteroscope through the vagina and into the cervical os to gain entry into the uterine cavity, inserting a catheter into each fallopian tube. The catheter delivers a small metallic implant into each fallopian tube. The presence of the obstructive implant causes scar tissue to form, completely blocking the fallopian tube.

Adiana® and Essure® are examples of implants inserted to induce occlusion of the fallopian tubes.

58600 Ligation or transection of the fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral

The physician ties off the fallopian tube or removes a portion of it on one or both sides. The procedure may be done through a small incision just above the pubic hairline.

58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral during the same hospitalization (separate procedure)

This procedure is done during the same hospital stay as the delivery (except for the episode of care, this code is the same as 58600).

+58611 Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)

The physician ties off the fallopian tube, or removes a portion of it on one or both sides, at the time of a cesarean section or intra-abdominal surgery.

This is an add-on code and is not subject to multiple procedure rules. This code is to be used as an add-on code to the primary codes for cesarean delivery, and should never be used as a standalone code.

According to OptumInsight's *Coders' Desk Reference for Procedures*, surgical techniques for the following codes are performed as:

Separate Procedures

According to the American Medical Association's (AMA's) guidelines, any code designated in CPT® as a "separate procedure" is usually a component of a more complex service or an integral component of another procedure. Such procedures are not reported separately when performed with other procedures and services in an anatomically-related area (e.g., same skin incision, same orifice, or same surgical approach).

It is appropriate to report a code identified as a separate procedure if performed alone, however. If the procedure is performed on the same calendar day as another related procedure, but during a different operative session, report both the separate procedure code and the primary service code and append modifier 59 *Distinct procedural service* to the separate procedure code.

Add-on Codes

Add-on codes describe additional intra-service work associated with the primary procedure. They are performed on the same day as the primary procedure, and must never be reported as a standalone code. Add-on codes are not subject to multiple procedure rules. Modifier 51 *Multiple procedures* should not be applied to add-on codes, nor should reimbursement be reduced.

58615 Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach

This reversible procedure is performed by either a vaginal or suprapubic approach. The physician blocks one or both fallopian tube(s) with a Silastic band, clip, or fallopian ring. The Falope ring, Yoon ring, Filshie clip, and Hulka clip are examples of devices used for fallopian tube occlusion.

58670 Laparoscopy, surgical; with fulguration of oviducts (with or without transection)

With the assistance of a fiber optic laparoscope, the physician performs laparoscopic electrical cautery destruction of an oviduct with or without completely cutting through the fallopian tubes. The physician may first insert an instrument through the vagina to grasp the cervix and manipulate the uterus during surgery before making a small incision just below the umbilicus, through which a fiber optic laparoscope is inserted. The physician places additional instruments through a second incision on the left or right side of the abdomen. The physician manipulates the tools so the pelvic organs can be observed, manipulated, and operated on with the laparoscope. To fulgurate the fallopian tubes, the physician inserts an electric cautery tool or a laser through a third incision adjacent to the fallopian tubes. The physician may cut the tubes and fulgurate the ends. The physician may transect the fallopian tubes.

58671 Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope rings)

The physician may first insert an instrument through the vagina to grasp the cervix and to manipulate the uterus during surgery. Next, the physician makes a small incision just below the umbilicus, through which a fiber optic laparoscope is inserted. A second incision is made on the left or right side of the abdomen. Additional instruments are placed through these incisions into the abdomen or pelvis. The physician manipulates the tools so the pelvic organs can be observed, manipulated, and operated on with the laparoscope. A third incision typically is made adjacent to the fallopian tubes and the devices (Silastic bands, clips, or Falope rings) are applied to the tubes.

Watch for Place of Service

Sterilizations can be performed in the office setting or in an outpatient or inpatient hospital setting. Sterilization procedures are considered to be elective. As such, be sure you verify coverage with the patient's insurance carrier before scheduling a procedure.

Lastly, some insurance carriers require special informed consent forms to be completed prior to the performance of these services. Check with the patient's insurance carrier for consent requirements prior to scheduling the procedure. CE

Lynda Vining, CPC, is employed by the University of Florida Jacksonville Physicians, Inc. She is the team lead for the Department of Obstetrics and Gynecology Business Group. She has over 40 years of experience in billing and coding for obstetrics and gynecology. She is an active member of AAPC's Nemours local chapter in Jacksonville, Fla.

Key Terms:

Tubal Sterilization

Approach · The anatomical location or region where access to a body organ is gained.

Cannulation · Insertion of flexible, hollow tubing (cannula or catheter) into a blood vessel, duct, or body cavity. A cannula may be used to insert implants that create scar tissue. The scar tissue occludes the fallopian tubes.

Fulguration · Destruction of living tissue using sparks from a high-frequency electric current. Alternate terms for this process are unipolar cautery/coagulation and bipolar cautery/coagulation.

Hysteroscope · A lighted optical instrument used in direct visual examination of the uterine cavity.

Incision (surgical) · Cutting into tissue or an organ.

Laparoscopy · Direct visualization of the peritoneal cavity, outer fallopian tubes, uterus, and ovaries using a thin, flexible fiber optic tube called a laparoscope.

Ligation · Tying off a blood vessel, duct, or tube with a suture or a thin wire.

Occlusion · Blockage, closure, or constriction. Occlusion of the fallopian tubes may be caused by scar tissue formed when implants are inserted or when a device is used to block or constrict the fallopian tubes.

Transection · To cut across a long axis: a cross sectional incision.

By Pam Brooks, CPC, PCS

Analyze Your EHR for ICD-10 Readiness

Determine, target, and fix your system's areas of greatest concern.

On Oct. 1, 2013, all diagnosis codes will be reported with a new format: ICD-10. By this time next year, you should be able to demonstrate with confidence that your billing system is capable of transmitting and receiving ICD-10 codes in the newer three to seven character, alpha-numeric format. You may still be worried, however, whether your provider(s) and electronic health records (EHRs) will be able to reproduce the documentation necessary to report ICD-10 with the required specificity. A preliminary detailed analysis can help determine whether your EHR will be ready, functional, and compliant to support this new format when that fateful day comes.

First Steps

Before you begin your analysis, familiarize yourself with ICD-10, particularly sections pertaining to your specialty. Obtain a draft copy, read the official guidelines, and note its conventions and code structure. There are two new exclusion notes (EXCLUDES 1 and EXCLUDES 2), and there is the new use of the "x" placeholder. You'll quickly see, more often than not, the guidelines are quite similar to ICD-9.

You should also be familiar with your EHR, and how the templates and software interfaces operate to drop default documentation in progress notes. Analysis of this interface is the key indicator if your EHR has the capability to illustrate the patient's condition with the specific detail required in ICD-10.

Although payers have not come right out and said so, coding experts suggest payers may limit the use of the "not otherwise specified" (NOS) and "not elsewhere classified" (NEC) codes (yes, they are available in ICD-10) in lieu of the more specific codes. Payer contracts mandate that we code to the highest specificity. This means that providers must document and diagnose in detail using one of the 79,000 codes devised for that purpose. The ubiquitous diabetes NOS code, 250.00 *Diabetes mellitus without complication type ii or unspecified type not stated as uncontrolled*, which crosswalks to ICD-10 code E11.9 *Type 2 diabetes mellitus without complications*, may not be acceptable by your payer, considering there are 204 other, more specific codes to report diabetes.

Although your billing software may be ICD-10 and 5010 compliant, if your EHR is not integrated, it may not have the capability to store and generate codes in the new alphanumeric format. The patient's past medical history and chronic conditions are all currently linked to ICD-9 codes.

Ask these questions of your vendor to see if your EHR is ready:

- ✓ Will my EHR be able to translate ICD-9 codes into the ICD-10 format?
- ✓ Will my EHR differentiate whether to report an ICD-9 or ICD-10 code based on the date of service?
- ✓ If my provider follows up on a condition that originated during the days of ICD-9, what will that encounter use as a diagnosis code after Oct. 1, 2013?

Work with information technology (IT) staff to examine these features in the EHR test environment.

Conduct the analysis specific to your practice's coding patterns beginning with your top 20-50 reported diagnosis codes. Use this list to evaluate your EHR's documentation capabilities for each of these codes when crosswalked to ICD-10 based on the additional codes, code descriptions and "code also" requirements for both ICD-9 and ICD-10.

For example, if one of your top ICD-9 codes is 300.00 *Anxiety state unspecified*, check the ICD-9 code description to see which other conditions are reportable using 300.00.

Savvy IT technicians and reasonably robust software can take the sting out of ICD-10 implementation if you can harness the software's abilities to work to your advantage.

Then, using a basic crosswalk as a preliminary guide (remember one-to-one crosswalks may be too nonspecific for payers to accept), determine which ICD-10 codes is appropriate for reporting each of those conditions. In this case, 300.00 can be used to report anxiety state, unspecified; anxiety neurosis; anxiety reaction; anxiety state (neurotic); and, atypical anxiety disorder. Then, use each of those descriptions to determine which ICD-10 codes are used to report them. Make a note of what is excluded in the ICD-10 descriptions that were included in ICD-9 because additional codes may have been created to be more precise. In this case, F41.1 *Generalized anxiety disorder* is used to report neurotic anxiety, F43.0 *Acute stress reaction* for an (acute) anxiety reaction, F41.8 *Other specified anxiety disorders* for atypical anxiety (other stated) disorder, and F41.9 *Anxiety disorder, unspecified* is used to report anxiety NOS. Remember: Payers may not accept NOS codes because we have so many, more specific code choices with ICD-10.

See if Your EHR Supports Documentation Requirements

When you've determined which ICD-10 codes could be used to report your common ICD-9 diagnoses, you will need to verify your EHR's ability to document the signs, symptoms, and etiology of each disease. A robust EHR with the ability to document a great deal of the history of present illness (HPI) information might not be a blessing because the mention of certain symptoms can entirely change the code that should be reported. With anxiety, for example, if the patient also reports panic attacks or social phobias, the final diagnosis may be more appropriately reported as F41.0 *Panic disorder [episodic paroxysmal anxiety] without agoraphobia* or F40.10 *Social phobia, unspecified*.

Take a look at your frequently reported ICD-9 NOS codes. As noted in the earlier example of the diabetes codes (250.xx), there are many ICD-10 codes that are extremely specific. Each has a very detailed code description, such as E11.00 *Type II diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)*.

To evaluate your EHR's abilities, ask yourself:

- ✓ Does it have the capability to illustrate this specificity?
- ✓ Is it a signs/symptom choice in the HPI template?
- ✓ Can you notate in the review of systems (ROS)?
- ✓ Is there an automated method (radio button or popup menu) to document this specificity?
- ✓ Will associated lab work provide supporting documentation?
- ✓ Where is the documentation stored in the EHR?
- ✓ Will your provider have to type in the details?
- ✓ Your provider could easily select this diagnosis from a drop-down ICD-10 list, but does his documentation support such a specific code?

This is why it's important to take a close look at your most common diagnosis codes, so you can determine whether your EHR needs updating or your providers require additional education.

Another new feature of ICD-10 is the concept of laterality. In the example of shoulder pain (ICD-9 code 719.41 *Pain in joint involving shoulder region*), ICD-10 asks us to report whether the pain is on the left or right (M25.511 *Pain in right shoulder* or M25.512 *Pain in left shoulder*). Interestingly enough, ICD-10 continues to allow providers to report shoulder pain without specifity (M25.519 *Pain in unspecified shoulder*). If you were to use this code, you would run the risk of not supporting medical necessity if your provider did not report in which shoulder the patient was experiencing pain. For this reason, claim edits can be helpful in substituting unspecified codes with more specific diagnosis codes prior to claim drop.

EHR Must Accommodate Specific Secondary Codes

Even with the multitude of extremely specific ICD-10 codes, there are still situations where secondary codes are required to be reported. This is a current ICD-9 expecta-

tion, but the secondary ICD-10 codes are just as detailed as the primary codes.

For example, with S04.011 *Injury of optic nerve, right eye*, ICD-10 asks you to use an additional code to identify any visual field defects or blindness (H53.4-H54). It's no longer sufficient simply to code the injury if other symptoms exist. Make sure your providers are aware that the secondary code is expected, and determine if your ICD-10 code library suggests it. If your billing system allows you to identify diagnosis codes when a secondary code is appropriate through a claim edit, you may wish to implement this.

You also should report the additional codes used to identify long-term medication use. Determine whether your EHR can be configured with a hyperlink to drop the additional code if the provider reviews that particular medication on the patient's electronic medication list. Savvy IT technicians and reasonably robust software can take the sting out of ICD-10 implementation if you can harness the software's abilities to work to your advantage.

Watch Out for Placeholders

The newest ICD-10 feature that has many coders (and IT professionals) worried is the concept of the placeholder. This is a dummy digit; an "x" placed typically in the fifth and/or sixth position to allow the additional placement of a seventh digit. This scenario is found when using injury and poisoning codes, and is used to report the timing of the patient encounter. For example, poisoning by antitussives, accidental, initial encounter is reported with T48.3x1A *Poisoning by antitussives, accidental (unintentional), initial encounter*. It will be important to make sure your EHR can document whether the visit represents the initial encounter, subsequent encounter, or sequela.

In the obstetrics world, the seventh digit is used to report multiple gestations. To report maternal care for breech presentation, fetus two, you would code O32.0xx2 *Maternal care for unstable lie, fetus 2*. Note that both the fifth and sixth digits require placeholders. Not only will your provider and EHR need to identify and report that the placeholders are required, but the documentation must be able to support which fetus is affected. Note also the use of the letter "O" and the number "0" (zero). Make sure your EHR can clearly identify these, and transfer them accurately into the 5010 format.

Use a Spreadsheet to Track EHR Capability

A good way to get a snapshot of this kind of analysis is to set up a worksheet template in either a database or spreadsheet format. For each of your frequently reported diagnosis codes, use a designated template. Headings can include the ICD-9 code, related ICD-10 codes, documentation criteria, EHR ability, and a comments field. Also include information in regards to secondary codes that might be required. The table below shows a partial example from a template set up to analyze diseases of lipoid metabolism. The comments will identify the specifics that need to be addressed within the EHR you're evaluating.

EHR Capability Analysis

ICD-9	ICD-10	Code Description	Documentation Verification	EHR Ability/Comments
	Excludes sphingolipidosis (E75.0-E75.3)			
272.0	E78.0	Pure hypercholesterolemia		
	Includes familial hypercholesterolemia		Must be documented in family history, and noted that it is related.	State whether familial or acquired (radio button?). Mention associated causes such as diabetes, or use of diuretics, beta blockers or estrogens (via text box).
	Includes Fredrickson's hyperlipoproteinemia, type IIA			Add hyperlipidemia in family history.
	Hyperbetalipoproteinemia		State any relation to hypothyroidism, renal failure, nephrotic syndrome, ETOH use or endocrine/metabolic disorder.	Use hyperlipidemia template: Indicate risk factors, comorbidity, and DM management (available). For ETOH, or other conditions, text into "other."
	Hyperlipidemia, group A			
	Low-density-lipoprotein-type-LDL hyperlipoproteinemia		Indicate lab values: LDL and triglycerides.	

Currently, most EHR vendors are aware of the ICD-10 conversion, but are tackling it from a 5010 perspective, not necessarily the documentation/compliance perspective.

Verify your documentation requirements directly from the code descriptions, but don't be afraid to look further to make sure you have the capability to report the most important elements of each diagnosis. If you are unfamiliar with the terminology or disease process, reference pathophysiology textbooks or query your providers to determine any related symptoms that support medical necessity. By using the existing EHR templates in your test environment, evaluate your EHR's ability to meet documentation requirements. Note any issues or workarounds that might affect the integrity of the patient's note. You will use this information to outline your action plan.

istock.com © Danie Laflor

Make Use of Your Data

After you've evaluated your EHR for quality documentation, what do you do with that information?

First, determine whether the issues you uncovered in your EHR software will be addressed in upcoming releases. Most EHR vendors are aware of the ICD-10 conversion, but are tackling it from a 5010 perspective, not necessarily the documentation/compliance perspective. You can work with your IT staff to determine whether template development or interface modification will improve your documentation capability. Having your analysis done in advance will allow you to target your areas of greatest concern, and will provide your IT staff with specifics regarding the modifications needed. You may decide that to expect physicians to assign their own ICD-10 codes is far too risky, and that pre-billing audits are necessary. By having this information in advance, you can prepare for, and support the use of, additional coding staff.

Working with providers on documentation training for ICD-10 will keep coders very busy for most of 2012 and 2013. Your analysis of the known issues in your EHR will help you devise a training plan specific to each diagnosis, so providers are aware of the pitfalls in terms of supplying incomplete documentation.

Besides obtaining an overview of the basics of ICD-10, providers will also need to understand how their code selections will have to be supported by the electronic notes they generate. Most providers who use an EHR are able to work through the templates and capture the data sufficient to support the patient's chief complaint, but might not be prompted to type additional information to support a very detailed diagnosis if it's not part of the EHR's default template. If it's not documented, a diagnosis—no matter how specific—is unsupported by the note. Start now by auditing a number of your providers' notes to see if they meet the highly-specific standards of ICD-10 coding. By using a team approach, you can present your results as an early opportunity for training, and at the same time get their clinical input as to the specific documentation they would expect to see for the various conditions they treat.

Your ICD-10 conversion will be significantly smoother, and your transition time shorter, if you take the time now to evaluate your EHR's readiness. If you are looking to buy an EHR in the near future, this can give you an idea of the right questions to ask. By getting a head start on the issues you might encounter on Oct. 1, 2013 you'll be that much more prepared to lead your practice into a successful conversion.

Pam Brooks, CPC, PCS, is the physician services coding supervisor at Wentworth-Douglass Hospital in Dover, N.H. She holds her bachelor's degree in Adult Education and Workplace Training from Granite State College, and is working on her master's in health administration at St. Joseph's College of Maine. She is the secretary of AAPC's Seacoast-Dover, N.H. local chapter.

By Michelle A. Dick

Colorado Takes the Initiative to Clean Up Claims

Standardizing claims statewide is good news for coders.

The Medical Clean Claims Transparency and Uniformity Act (House Bill 10-1332) was signed by Colorado's Governor Bill Ritter May 12, 2010. The bill requires the executive director of the Colorado Department of Health Care Policy and Financing (HCPF) "to convene a task force of industry and government representatives to develop a standardized set of payment rules and claim edits to be used by payers and health care providers in Colorado." The standard set will apply to all payers having contracts with providers in Colorado. The Colorado Medical Society was instrumental in passing this bill, also known "informally" as the Colorado Clean Claims Initiative.

The goal of the Colorado Clean Claims Initiative is to create one consistent set of edits everyone knows and uses to ensure a claim is coded, submitted, and processed cleanly the first time.

Why Colorado?

Task force member **Wendi Healy, CPC**, of Colorado's Western Nephrology said, "Colorado is a very progressive state when it comes to health care reform. The Colorado Blue Ribbon Commission for Health Care Reform (locally known as the 208 Commission) was created by the Colorado legislature in 2006 to decrease health care costs for Colorado residents, and has many tiers to it; one of which is to reduce administrative costs in the health care system."

The co-chairs of the task force are **Marilyn Rissmiller** of Colorado Medical Society and **Barry Keene** from Keene Research and Development. Healy told *Coding Edge* that Keene is a Colorado resident who has not been employed in the health care arena, "but is a well-educated consumer, who saw what a monster we have all created in the health care industry and was willing to step up to the plate to help change it."

Vermont has also passed a law directing investigation of the value of such standardizations, and the AMA is supporting the Vermont Medical Society in its efforts," according to American Medical Associations (AMA's) Standardization of a Code-editing System White Paper (November 2011, page 6).

HCPF Creates a Task Force of Claims Experts

The task force is represented by 28 individuals from AMA, Colorado Medical Society, Colorado Hospital Association, Anthem/Wellpoint, UnitedHealthcare, Kaiser Permanente, Rocky Mountain Health Care (RMHC), Aetna, McKesson, OptumInsight , NHXS, Relative Value Studies, and ambulatory surgical centers (ASCs); and is made up of coders, billers, payers, vendors, and physicians chosen through an online application. Loaded with Certified Professional Coders (CPCs®), the task force includes these AAPC credentialed members:

- **Valerie Clark, CPC,** represents payer-side, Kaiser
- **Rebecca Craig, CPC-H,** Harmony Surgery Center, CASCA member
- **Kimberly Davis, CPC,** physician billing at University Hospital
- **Wendi Healy, CPC,** Western Nephrology, represents Colorado Medical Group Management Association (MGMA)
- **Amy Hodges, CPC, CPC-I,** billing revenue cycle management, Bloodhound Technologies, Contracting w/ States to implement NCCI for Medicaid
- **Ryshell Schrader, CPC,** Community Reach Center, (MGMA)
- **Nancy M. Steinke, CPC, CPC-H,** represents payer-side, RMHP
- **Beth Wright, CPC,** Anthem, CCI committee chair

There are several other AAPC members on the team, as well. According to Healy, "The task force has grown since they originally started. Their goal when choosing the task force was to be sure they had good representation."

At one of the task force meetings someone from the payer-side suggested they make a recommendation to hire certified coders. Healy said, "Absolutely!"

An HCPF Hot Topics Legislative Report from Sept. 30, 2010 says the task force members must have these qualifications:

- Expertise in the areas of coding, payment rules, and claim edits
- Hands-on experience with the impact they have on payment of professional health insurance claims
- Expertise including a technical understanding of the logic surrounding unbundling, mutually exclusive, multiple procedure reduction, global surgery days, place and type of service, assistant surgery, co-surgery, team surgery, total/professional/technical splits, bilateral procedures, anesthesia services, and the effect of CPT® and HCPCS Level II modifiers

Healy said, "It is the first time the industry has really put together this many players in the game and have everybody just sit down and say 'even though we are speaking the same language, we aren't.' For example, when we first sat down we discovered what we call a claim edit, payers call a claim audit." Healy continued, "We told them our side doesn't like the word audit; let's not use the word audit."

The task force's timeline for critical mileposts is:

- Dec. 2, 2010 – Begin work and develop a base set of standardized payment rules and claim edits
- Nov. 30, 2012 – Adopt base set
- Dec. 31, 2013 – Adopt complete set (by filling in gaps)
- Dec. 31, 2013 – Develop recommendations on implementation and maintenance
- 2014+ – Implement

Task Force Creates Framework for Initiative

In the task force's current effort to move towards a standard code editing system, they will identify a base set of rules and edits using these existing national industry sources:

- National Correct Coding Initiative (NCCI) edits
- The Centers for Medicare & Medicaid Services (CMS) directives, manuals, and transmittals
- Medicare Physician Fee Schedule (MPFS)
- CMS national Clinical Laboratory Fee Schedule
- HCPCS Level II coding system and directives
- CPT® coding guidelines and conventions
- National Medical Specialty Society coding guidelines

Healy said, "We are not recreating the wheel. We are looking at industry standards that are already in place, CPT®, HCPCS, and basically unifying things."

First Step of Many: NCCI Evaluation

The task force is developing an initiative to consider what would happen if it started with NCCI as a "skeleton" for the bundling process through an NCCI-sub-group team, which analyzes NCCI concepts and methodologies, to understand its application and to make recommendations to the HB 10-1332 Colorado Task Force. The analysis is based on relative value units (RVUs). They evaluate the NCCI edits where a denied code has the higher RVU.

"This has been really informational on how codes get the way they are, how we in turn use that information, how it's interpreted on both sides of this, and choosing language that is acceptable to both sides," Healy said. "We started with the NCCI edits. There is a company called NHXS. They work mostly on the physician-side and run all the claims up against the edits." NHXS has "a list of all of the edits that all of the insurance companies are using." They are able to show the task force the frequency with which specific CPT®, NCCI, or other types of edits occur.

NHXS has "been incredibly helpful with bringing data to the table that can show us where we may run into issues," Healy said. "They run thousands and thousands and thousands of coding edits in their databases. They show us the data where there are times when NCCI turns the code upside down and pays the lower value." NHXS uses this vast library to determine if a payer's edit runs counter to generally accepted conventions. "They use this information to show us why we can and can't do certain types of things," Healy said. "The NCCI is only the first issue we are tackling. We will also be reviewing modifier usage, place of service code rules, assistant at surgery rules, and many other areas."

What Does This Mean for Coders?

At one of the task force meetings someone from the payer-side suggested they make a recommendation to hire certified coders. Healy said, "Absolutely!" The task force realizes that one of the problems

Continued on page 48

By Lynn S. Berry, PT, CPC

Medical Technology Is Making Humanism a Lost Art

New health care regulations may help bring humanity back to medicine.

A lot has been written lately about the loss of humanism in medicine. In medicine, "humanism" means seeking to understand the patient as a whole person (including the patient's individual values, goals, and preferences), rather than as a set of symptoms or data points. The lost art of palpation—truly "hands on" medicine—and the importance of making a physical, mental, and emotional connection with the patient, has been discussed by physicians such as Abraham Verghese, MD ("Culture Shock – Patient as Icon, Icon as Patient," *New England Journal of Medicine*; Dec. 25, 2008) and Teresa A. Gilewski, MD, in development of the "Art of Medicine" lecture series at Memorial Sloan-Kettering Cancer Center, and in her film "The Physician as the Patient."

"The Doctor" by Sir Luke Fildes (1887) Public Domain

The "human element" in medicine is fundamental. The caregiver who foregoes palpation, auscultation, and personal observation may miss not only a diagnosis, but also the opportunity to connect with the patient in a way that meaningfully improves care. Genuine interest in, and attention to, whether a patient is taking his medication and how he is responding to treatment are important, as are listening to a patient's concerns and understanding the entire scope of his or her emotional, social, and medical issues. Patients are more inclined to be compliant and follow the care plan provided to them when they feel as though they can communicate freely with their providers, that the entire staff is interested in them as a person, and that they are part of the decision-making process.

Medical Humanist Helps Improve Health Outcomes

In 2002, the Institute of Medical Humanism introduced a "medical humanist" at a regional cancer center in Vermont. The medical humanist's role was to interpret physician language, communicate that to the patient, and then write the patient's experience into the medical record. Evaluating the results of this pilot program, the institute concluded, "Incorporating a medical humanist on an inter-disciplinary team served to bridge the differences in language, facilitated doctor-patient communication, fostered collaborative health care decision-making and helped to improve health outcomes" (see http://communicationinmedicine.org/programs/medicalhumanist.html).

Technology Creates Distance

The program's success also reveals a sad reality: Patients and physicians are no longer communicating one-on-one. Although medical science has made amazing strides in recent decades, an increasing reliance on technology seems to have created a greater distance—psychologically as well as physically—between patients and physicians.

New Programs Seek to Bridge the Communication Gap

Concern about the "patient experience" may seem out of place in evidence-based practice, but health care regulations now in development include requirements for patient satisfaction.

On the hospital side, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions (www.hospitalcompare.hhs.gov) ask for patient feedback regarding nurses, doctors, hospital staff, and with their own pain control. These measures will be continued in 2012 and include reimbursement provisions, according to the 2012 Medicare Outpatient Prospective Payment System final rule. As noted in a *HealthLeaders Media* Intelligence Unit report, "Patient Experience: Help Wanted," leaders are struggling to attain top scores and meet these and other incentives for improving patient satisfaction.

As another example, the Medicare Shared Savings Program will reward accountable care organizations (ACOs) that lower health care costs while meeting performance standards on quality of care and putting patients first. ACOs that do not meet these standards will not be eligible to share any savings realized under the ACO model.

The 2012 Medicare Physician Fee Schedule final rule likewise discusses a new value-based payment modifier to be phased in beginning in 2015. Some of the quality measures involve patient safety, as well as the patient experience and functional status.

Getting caregivers more involved with their patients is quickly becoming a fiscal priority. Physicians may have to adjust schedules to spend more time with patients, and will have to take greater advantage of new care models. For example, other providers in their medical home or office structure may be able to get telephonic results for congestive heart failure (CHF); patient weights; provide patients with an easily understood home program to follow; follow up with

> Although medical science has made amazing strides in recent decades, an increasing reliance on technology seems to have created a greater distance—psychologically as well as physically—between patients and physicians.

the patient at home; and call patients regularly to determine whether they need additional assistance, changes in their prescriptions, or an appointment to see the physician. This allows for expedient and safe treatment for the patients who are not personally seen as often, and for more time available when they do come into the office.

The new practice models are old models revived in a new environment of higher health costs and new technology. We can incorporate humanism and compassion into our medical practice to increase revenue, patient compliance, and satisfaction.

Lynn Berry, PT, CPC, had more than 35 years of clinical and management experience before beginning a new career as a coder and auditor and later becoming a provider representative for a Medicare carrier. She now has her own consulting firm, LSB HealthCare Consultants, LLC, furnishing consulting and education to diverse provider types, and is a senior coder and auditor for the Coding Network. She has held a variety of offices for her AAPC local chapter and continues as one of the directors of the St. Louis West Missouri local chapter.

newly credentialed members

Abigail Reid, **CPC**
Adeniyi E Adeniran, **CPC-H**
Adrian Villas, **CPC**
Adriana Elizalde Iglesias, **CPC**
Aisha Lajuan Hagins, **CPC**
Alan Bengzon, **CPC-P**
Alexis Mariski, **CPC**
Alisha Evans, **CPC**
Alisha Glazier, **CPC-H**
Alicia R M Phillips, **CPC**
Allen Smith, **CPC**
Amanda Brooks Hiers, **CPC**
Amanda N Ho, **CPC**
Amanda Leigh Johnson, **CPC**
Amanda Jo Oas, **CPC**
Amanda Schweich, **CPC**
Amanda Weeks, **CPC**
Amber Holly Vos, **CPC**
Amy Bulthuis, **CPC**
Amy B Williams, **CPC**
Amy Killingsworth, **CPC**
Amy-Jo Cathleen Kinion, **CPC**
Andra Striebeck, **CPC**
Andrea Barrett, **CPC**
Andrea Kassik, **CPC**
Andrea Riccelli, CPC, **CPC-H**
Angela Bayda, **CPC**
Angela D Stephenson, **CPC**
Angela Hill, **CPC**
Angela Whitbeck, CPC, **CPC-P**
Angeli Marie Abbey, CPC, **CPC-H**, CPMA
Anita Candler, **CPC**
Anita Jo Spencer, **CPC**
Ann M Carr, **CPC**
Anne Gard, **CPC**
Anne Stephens, **CPC**
April Banks, **CPC**
April Sanchez, **CPC**
Aspen Taylor, **CPC**
Ayanira Rivera, **CPC**
Ayodele Oyebowale Aiyeola, **CPC-H**
Barbara Couch, **CPC**
Barbara Frizzell, **CPC**
Barbara S Weavel, **CPC**
Barbara S Weavel, **CPC**
Becky D Miller, **CPC**
Becky Wilkerson, **CPC**
Bernadette Widaman, **CPC**
Bernice G Burmeister, **CPC**
Beth Rahlf, **CPC**
Betty Carter, **CPC**
Beverly Glass, **CPC**
Beverly J Nester, **CPC**
Bibi Nazia Rahman, **CPC**
Blanca Lopez, **CPC**
Blanca Vasquez, **CPC**
Bonnie Jones, **CPC**
Bonnie Flannagin, **CPC**
Brandi Teague, **CPC**
Brandi Welch, **CPC**
Brenda Marie Johnson, **CPC**
Brenda Madsen, **CPC**
Brenda Rodriguez, **CPC**
Bridget Levitt, **CPC**
Brittany Nicole Neftzer, **CPC**
Candice B Williams, **CPC**
Candy James, **CPC**, CIRCC
Carey E Puwal, **CPC**
Carie Nay, **CPC**
Carla Fernandez, **CPC**
Carla Kerr, **CPC**
Carla McEntire, **CPC**
Carly Helm, **CPC**
Carmen Caridad Diaz-Buil, **CPC**
Carmen D Ruiz, **CPC**
Carol Denson, **CPC**
Carol Ann McDermott, CPC, **CPC-P**
Carol Vandercar, **CPC**
Carolina Reynoso, **CPC**
Carrie Price, **CPC**
Cassandra Reese, **CPC**
Catharine Ann Hervey, **CPC**
Cathy Wied, **CPC**
Charleen Gresham, **CPC**
Charlene Parks, **CPC**
Charlotte Patterson, **CPC**
Charlotte Trice, **CPC**
Cheryl A Paoli, **CPC**
Cheryl Zoll, **CPC**
Chiquina D Williams, **CPC**
Christa Nicholson, **CPC**
Christen Grob, **CPC**
Christina Kyler-Shafer, **CPC**
Christina R Segura, **CPC**
Christine Guthery, **CPC**
Christine Ringer, **CPC**
Christine Scannell, **CPC**
Christine Steelman, **CPC**, CIMC
Christine Whitwell, **CPC**
Christy Uchida, **CPC**
Cindy DiMiceli, **CPC**
Cindy G Gillum, **CPC**
Cindy Katzfey, **CPC**
Cindy Merrill, **CPC**
Cindy Shipley, **CPC**
Claudia Wynn Long, **CPC**
Cliseria Ortiz, **CPC**
Colleen Blair, **CPC**
Connie Clinard, **CPC**
Connie Stephey, **CPC**
Corinne A Nason, **CPC**
Corinne Gurnot, **CPC**
Cynthia Ann Moeller, CPC, **CPC-H**
Cynthia Keith, **CPC**
Cynthia Ottinger, **CPC**
Cynthia S Empson, **CPC**
Cynthia Stephenson, **CPC**
Cynthia Wnukowski, **CPC**
D'Linda Sue Wallace, **CPC**
Dale Hughes, **CPC**
Dana Dawson, **CPC**
Danielle A Ketelaar, **CPC**
Danielle C Sadowy, **CPC**
Danielle Mills, **CPC**
Danielle Tate, **CPC**
Darcilla Olshavsky, **CPC**
Dawn Briggs, **CPC**
Dawn M Sehl, CPC, CPC-H, **CPC-P**
Dawn Sleeper, **CPC**
Deanna A Coon, **CPC**
Debbie Jespersen, **CPC**
Debbie Morgan, **CPC**
Deborah Bordador, **CPC**
Deborah Johnston, **CPC**
Deborah L Meyer, **CPC**
Deborah L Miller, **CPC**
Deborah Wilson, **CPC**
Debra K Manning, **CPC**
Debra Northrup, **CPC**
Debra Kay Wadelton, **CPC**
Debra Kirby, **CPC**
Debra White, CPC, **CPC-H**
Delois Darlean Crawford, **CPC**
Delores Diane Tressel, **CPC**
Denise Eldredge, **CPC**
Denise Kahl, **CPC**
Denise Korzetz, **CPC**
Denise Walsh, **CPC**
Diana Alvira, **CPC**
Diana Patricia Salazar, **CPC**
Diane Scheer, **CPC**
Diana Simmons, **CPC**
Dianna Bland, **CPC**
Dina Turner, **CPC**
Dolores Salazar-Hillegonds, **CPC**
Donna Carrier, **CPC**
Donna L Lopez, **CPC**
Donna Toney, **CPC**
Dorita Pamphile-Laurent, **CPC**
Dulcie Mahmud, **CPC-H**
Edelmira Rodriguez, **CPC**
Edith Aquino, **CPC**
Eileen Monsorno, **CPC**
Elaine Thelwell, **CPC**
Eleanor Riley, **CPC**
Elizabeth Loftus, **CPC**
Elizabeth A Ontiveros, **CPC**
Emily Craddock, **CPC**
Eva Carlos, **CPC**
Eva Kwan, **CPC**
Fay W Blackburne, CPC, **CPC-H**
Fia Yarian, **CPC**
Frances J McCabe, **CPC**
Francesca Ann Cristofano, **CPC**
Francis Motuwe Mosoke, **CPC**
Frank Airhart, **CPC**
Gail Mason, **CPC**
Geeta Patel, **CPC**
Georgiana Williams, **CPC**
Ginger Blackwood, CPC, **CPC-H**
Gini R Burr, **CPC**
Gladys Larrobis, **CPC**
Glenn Ilustrisimo, **CPC**
Gloria Ionta, **CPC**
Grace Britsch, **CPC**
Grace Minix, **CPC**
Greta Kudirkaite, **CPC**
Haley Vogel, **CPC**
Haojie Jessica Hu, CPC, **CPC-H**
Heather Anne Smith, **CPC**
Heather Bridges, **CPC**
Heather Joseph-Chupp, **CPC**
Heather Littell, **CPC**
Heather M Joniaux, **CPC**
Heather Vick, **CPC**
Hollie Shae Luther, **CPC**
Holly Mengwasser, **CPC**
Infanta Marie Catbagan, **CPC**
Isabel Casaus, **CPC**
Ivan I Caguiat, **CPC**
Jaclyn D Cronch, **CPC**
Jacqueline Grande Winthrop, **CPC**
Jacqueline Vazquez, **CPC**
Jacy Michiko Miyasato Hanagami, **CPC-H**
Jamie Wirtz, **CPC**
Jana Murray, **CPC**
Jane M Gleason, CPC, **CPC-H**
Jane Mcgarry, **CPC**
Janet Begert, **CPC**
Janet Hunker, **CPC**
Janie L Dickerson, **CPC**
Janika Joy Pannell, **CPC**
Jansi Rani J, **CPC**
Jaymie LaBarbera Citelli, CPC, **CPC-H**
Jean Palmer, **CPC-H**
Jean Roberson, **CPC**
Jeanette Palmer, **CPC**
Jeanette Patricia Bailey, **CPC**
Jeanine Doris Tableman, **CPC**
Jeanne Vista, **CPC**
Jeanniee Nolan, **CPC**
Jennifer Ann Bartram, **CPC**
Jennifer Furnia, **CPC**
Jennifer K.W. Dadoy, **CPC**
Jennifer Gonzalez-Ocasio, **CPC**
Jennifer Gorsuch, **CPC**
Jennifer D Hollins, **CPC**
Jennifer O'Neal, **CPC**
Jennifer Riggle, **CPC**
Jennifer Rothell, **CPC**
Jennifer Van De Velde, **CPC**
Jenny Dawn Cooper, **CPC**
Jerry W Van Meter, **CPC**
Jill Corbett, **CPC-H**
Jo Anne McMillan, **CPC**
Joanne Thomas, **CPC**
Jodi Beebe, **CPC**, COBGC
Johnnie Alphonse Yates, **CPC**
Jorell Lawrence, **CPC**
Jorge Canepa, **CPC**
Joseph Carangi, **CPC**
Joy Bordon, **CPC**
Joyce Tucker, **CPC**
Judith Warnock, **CPC**
Judy Beaver, **CPC**
Judy Kay Sowards, **CPC**
Julie Sims, **CPC**
June Elizabeth Lockhart, RN, CPC, **CPC-P**
Justine Dusanek, **CPC**
Kara Boogar, **CPC**
Karen Yoho, **CPC**
Karen Benvenisti, **CPC**
Karen Marie Lopinski, **CPC**
Karen Michel, **CPC-H**
Karen Wallace, **CPC**
Kari Painter, **CPC**
Kathleen A Bailey, **CPC**
Kathleen A Corner, **CPC**
Kathleen Cartwright, **CPC**
Kathryn Cutler, **CPC**
Kathryn Jones, **CPC**
Kathleen LaMere, **CPC**
Kathryn Robillard, **CPC**
Kathy Shirlene Baker, **CPC**
Kathy J Washburn, **CPC**
Kathy Lane, **CPC**
Kathy Martin, **CPC**
Katina Christine Tucker, **CPC**
Katrina Woodring, CPC, **CPC-P**
Kayla Register, **CPC**
Kelley Smith, **CPC**
Kelly A Stevens, CPC, **CPC-H**
Kelly Ditsche, **CPC**
Kelsey Williamson, CPC, **CPC-H**
Kendra Ann Sexton, **CPC**
Kenyetta Denise Johnson, **CPC**
Kerry Edwards, **CPC**
Keyla Bybee, **CPC**
Kim Henry, **CPC**
Kim McDaniel, **CPC**
Kimberly Swindell, **CPC**
Kimberly A. McAllister, **CPC**
Kimberly Banks, **CPC-H**
Kimberly Burke, **CPC**
Kimberly Canonic, **CPC**
Kimberly Coleman, **CPC**
Kimberly Huff, **CPC-H**
Kimberly Justin, **CPC**
Kimberly R Burns, **CPC**
Krista Corazzo, **CPC**
Kristene Sue Hanna, **CPC**
Kristin Connolly, **CPC**
Kristina Anderson, **CPC**
LaDawn Brown, **CPC**
Larry Lucas, **CPC**
Lashaunda Latrice Clemon, **CPC**
Latoya Dukes, **CPC**
Laura Annette Colburn, **CPC**
Laura Jenkins, **CPC**
Laura Lynch, **CPC**
Laurie Foret, **CPC**
Lavarne Eyvette McCloud, **CPC**
LeeAnn Bauer, **CPC**
Leslie Carney, **CPC**
Leslie Jones, **CPC**
Leslie Marie Pitt, **CPC**
Leslie-Ann Elizabeth Manganiello, **CPC**
Leticia Vallejo, **CPC**
Linda Bauer, **CPC**
Linda Beyer, **CPC-H**
Linda Lester, **CPC**
Linda Thomas, **CPC**
Lisa Braloski, **CPC-H**
Lisa Enriquez, **CPC**
Lisa Jane Gassaway, **CPC**
Lisa Jarvis, **CPC**
Lisa Jennette, **CPC**
Lisa Ratliff Mize, **CPC-H**
Lori Hayes, **CPC**
Lori Hermes, **CPC**
Lori Ann Oates, **CPC**
Lori Miyo Inouye-Yamashita, **CPC**
Lori-Lee Bush, **CPC**
Lorinda Scott, **CPC**
Lorri E Tolliver, **CPC**
Lory Savino, **CPC**
Lusiley Milan, **CPC**
Lynne Cooper, **CPC**
Madeline Kay Cauley, **CPC**
Magela D Arrillaga, **CPC**
Mai Casler, **CPC**
Mara Lundquist, **CPC**
Marc Madden, **CPC**
Marco Antonio Aguilar, **CPC**
Marcus Stewart, **CPC**
Margaret L Stachowiak, **CPC**
Margarita Rivero, **CPC**
Margo Talton, **CPC**
Maria Germano, **CPC**
Mariann Hyde, **CPC**
Marie Fitch, **CPC**
Marisol Saldana, **CPC**
Marrashaughne M Gonzalez, **CPC-H**
Marshelle Powell, **CPC**
Martha J Davis, **CPC**
Mary Ann Moosman, **CPC**
Mary Ashton Cason, **CPC**
Mary Davene Gaddy, **CPC**
Mary E Birg, **CPC**
Mary Graves, **CPC**
Mary E Hentrup, **CPC**
Mary E Little, **CPC**
Maryann Santana, **CPC**
Maryetta Compton, **CPC**
MaryKate Oriatti, **CPC**
Maureen E Russo, **CPC**
Megan Whiting, **CPC**
Megan Yoho, **CPC**
Melanie Fair, **CPC**
Melissa Brooke Smith, **CPC**
Melissa Skees, **CPC**
Melissa Yates, **CPC**
Michelle L Adams, **CPC**
Michelle Castro, **CPC**
Michelle Hamilton, **CPC**
Michelle J Palmisano, **CPC**
Michelle Maves, **CPC**
Michelle Perera, **CPC**
Michelle Swanstrom, **CPC**
Mitze Kelley, **CPC**
Mitzie Chandler, **CPC**
Monica Parker, **CPC**
Monica Till, **CPC**
Monika De Leon, **CPC**
Monique Fawks, **CPC**
Monique Nicole Hipp, **CPC**
Morgan Alyssa Rutkowski, **CPC**
Nakia R Martineau-Grimes, **CPC**
Nancy Barry, **CPC**
Nancy L Vanorse, **CPC-H**
Natacha Jean, **CPC**
Natalie Culhane, **CPC**
Natalie Pafford, **CPC**
Natalie Turner, **CPC**
Neela Dhanpatie Dudhnath, **CPC**
Neomia Shapri Nash, **CPC**
Nicolas Ramos, **CPC**
Nicole M Walker, **CPC**
Nina Sanders, **CPC**
Norgen Medina, **CPC**
Norma Snelling, **CPC**
Noviana Natadihardja, **CPC**
Olga Fuentes, **CPC**
Olivia Naomi Harris, **CPC**
Ona Rae Henderson, **CPC**
Paige Elliott, **CPC**
Pamela Cross Schaaff, **CPC**
Pamela Mayers, **CPC**
Pandora Smallwood Rascoe, **CPC**
Parris Yarges, **CPC**
Patricia Baybutt, **CPC**
Patricia L Lopez, **CPC**
Patricia M Ward, **CPC**
Patrick R Guilfoyle, **CPC**
Patty Mogel, **CPC**
Paul Dennis Faringer, **CPC**
Paula Mada, **CPC**
Paula Legnon, **CPC**
Paula Roy, **CPC**
Paulette Sharon Wagner, **CPC**
Penelope Sanchez, **CPC**
Penny Luepke, **CPC**
Perla Valdez, **CPC**
Rachel Anne DeFauw, **CPC**
Rachel E Hudnell, **CPC**
Rachel Lynn Hannon, **CPC**
Rebecca Banas, **CPC**
Rebecca Hovis, CPC, **CPC-P**, CGIC
Rebecca R King, CPC
Rebecca Lynn Zoellich, CPC, **CPC-P**
Rebecca Powell, **CPC-H**
Renee Jones-Sherwood, **CPC**
Renee Samuel, **CPC**
Renee Thompson-Franklin, **CPC**
Richard Lucibella, **CPC**

Rita Ross, **CPC**
Robert Paul Wenzl, CPC, **CPC-P**
Robin Rochelle, CPC
Roksana Hoque, CPC
Rosaura Peralta, **CPC**
Rose Kesanghe Udoumana, CPC, **CPC-P**
Ryan J Murray, **CPC**
Ryan Lacen, **CPC**
Saima Idrees, **CPC**
Sandra Glovier, **CPC**
Sandra Henderson, **CPC**
Sandra Howell, **CPC**
Sansharee Trimble, **CPC**
Sara L Georg, **CPC**
Sara Sardinas, **CPC**
Sara Simpson, **CPC**
Sarah P Hayes, **CPC**
Shann Bates, **CPC**
Shannon Kathleen Hicks, **CPC**
Shanthi Karunakaran, **CPC**
Sharon A Fogelsonger, **CPC**
Sharon Posey, **CPC**
Sharyl NT Shultz, **CPC**
Shauna Self, **CPC**
Shawna Kaufman, **CPC**
Shelley Ann Hargraves, **CPC**
Shelly Mandell, **CPC**
Shelly Michele Pinkston, **CPC**
Sherri L Bryant, **CPC**
Sherry L Klump, **CPC**
Sheryl Woody, **CPC**
Sirani Singh Pooran, **CPC**
Sonja D Moon, **CPC**
Sonya L Spight, **CPC**
Sravanti Surender, **CPC**
Srinath Rajendran, **CPC**
Stacy McPhee, **CPC**
Stephanie E Baisley, CPC, **CPC-H**
Stephanie Lynn Chance, **CPC**
Stephanie Gregory, **CPC**
Steven Y Orimoto, **CPC**
Summer D Hunsaker, **CPC**, CCVTC
Sundra S Jones, CPC, CPCO, **CPC-P**, CPMA, CPC-I, CHONC
Susan Blankenship, **CPC**
Susan J Csiki, **CPC**
Susan Lombard, **CPC-H**
Susan Lynne Irvin, **CPC**
Susan Michele Thormann, **CPC**
Susan Peticca, **CPC**
Svetlana Ermakova, **CPC**
Sylvia Nuss, **CPC**
Synthia Burns Thomas, **CPC**
Tabitha Swanson, **CPC**
Tamara Kenesha Bailey, **CPC**
Tambra Michelle Tellis, **CPC**
Tammy Goodell, **CPC**
Tamra Cochran, **CPC**
Tara Wyckoff, **CPC**
Teena Dalton, **CPC**
Temiko M Holmes, **CPC**
Teresa Kaye, **CPC**
Teresa R Delgado, **CPC**
Teri Urban, **CPC**
Terri King, **CPC**
Terri Spear, **CPC**
Theresa Ann Mohr Seefelt, **CPC**
Theresa Lyn Vinson, **CPC**
Theresa M Carter, **CPC**
Theresa Odoms, **CPC**
Tiffani Swanson, **CPC**
Tina Marie Yanacek, CPC, **CPC-H**
Tina Renee Harris, **CPC**
Tracey Hardwick, **CPC**
Trebba Putnam, **CPC**
Trina Allen, **CPC**
Trisha Smith, **CPC**
Valentine Garabedian, **CPC**
Vashion A Williams, **CPC-H**
Vicki Lynn Mohler, **CPC**
Vicki Saul, **CPC**
Victoria Haley, **CPC**
Victoria Hubbard, **CPC**
Viridiana Jones, **CPC**
Waverlyn Alexander, CPC, **CPC-P**
Wendy Lang, **CPC**
Yahaira Gonzalez, **CPC**
Yanet Rodriguez, **CPC**
Yeline Margarita Falek, **CPC**
Yohanni Caraballo, **CPC**
Yong Li, **CPC**
Yvette Dill, **CPC**
Zuriharri Pannell, **CPC-H**

Apprentices

Aarti Shri Ramraj Yadav, **CPC-A**
Adele Gibilisco, **CPC-A**
Adrienne Harding, **CPC-A**
Adrienne Kay Hankins, **CPC-A**
Afroz Musa Shaikh, **CPC-A**
Agena Foiles, **CPC-A**
Agnes Elizabeth Short, **CPC-A**
Aida Correa, **CPC-A**
Aimee E Plowman, **CPC-A**
Aimee Hill, **CPC-A**
Alba Peralta, **CPC-A**
Alexandrea M Hamann, **CPC-A**
Alexis A. Parrillo, **CPC-A**
Alexis Mason, **CPC-A**
Alice Burklin, **CPC-A**
Alicia Snipes, **CPC-A**
Alisha Collins, **CPC-A**
Alison Bossie, **CPC-A**
Alysia Faith Field, **CPC-A**
Alyssa Anna Anderson, **CPC-A**
Amanda Birmingham, **CPC-A**
Amanda Dimartino, **CPC-A**
Amanda Holt, **CPC-A**
Amanda Tinch, **CPC-A**
Amber A Grogan, **CPC-A**
Amber Chaploney, **CPC-H-A**
Amber C Rose, **CPC-A**
Amber E Seward, **CPC-A**
Amber Hunter, **CPC-A**
Amber Lynn Deemie, **CPC-A**
Amber Michelle Mark, **CPC-A**
Amber N. Thomas, **CPC-A**
Amber Wallish, **CPC-A**
Ambie Newsome, **CPC-A**
Ameet Arvind Shah, **CPC-A**
Amelia Kelley, **CPC-A**
Amit Kumar Singh, **CPC-A**
Amy Nicole Musgrove, **CPC-A**
Amy Nicole Musgrove, **CPC-A**
Amy St Pierre, **CPC-A**
Ana Beauchamp, **CPC-A**
Ana Mares, **CPC-A**
Ana Maria Gomez, **CPC-A**
Anandan Durai, **CPC-A**
Andrea Davis, **CPC-A**
Andrea Fults, **CPC-A**
Andrea P Griese, **CPC-A**
Angela Hines, **CPC-A**
Angel Duvall, **CPC-A**
Anita Thomas, **CPC-A**
Annalisa Sadler Whitfield, **CPC-A**
Anna Stewart, **CPC-A**
Anne Coffey, **CPC-A**
Annette Hoffman, **CPC-A**
Annika J Thrower, **CPC-A**
April Maddox, **CPC-A**
April Riffle-Holland, **CPC-A**
Ashot Djavakhian, **CPC-A**
Asma Moinuddin, **CPC-A**
Barbara Kudsk, **CPC-A**
Betsy Huggins, **CPC-A**
Beverly Froemling, **CPC-A**
Beverly Gorecki, **CPC-A**
Brandelynn Gilman, **CPC-A**
Brenda McClanahan, **CPC-A**
Brenda M Chabre, **CPC-A**
Brenda Tobar, **CPC-A**
Brigitte Kornblum, **CPC-A**
Callie Roseman, **CPC-A**
Candace Hatfield, **CPC-A**
Candis M. Godley, **CPC-A**
Carmen Lillian Weathers, **CPC-A**
Carole Carnline, **CPC-A**
Carolyn Vanessa Claiborne, **CPC-A**
Cathy Acree, **CPC-A**
Ceara Valenti, **CPC-A**
Celeste Vasquez, **CPC-A**
Charlotte Bellestri, **CPC-A**
Charlotte Samatra, **CPC-A**
Chaundra Dickinson, **CPC-A**
Cherelle Watson, **CPC-A**
Cherrica Mitchell, **CPC-A**
Cheryl Rafter, **CPC-A**
Cheryl Swan, **CPC-A**
Christel Faye Nevells, **CPC-A**
Christina Krueckeberg, **CPC-A**
Christina Tutor, **CPC-A**
Christine Pulcine, **CPC-A**
Christy Lemuz, **CPC-A**
Crystal Colon, **CPC-A**
Crystal Conradson, **CPC-A**
Cynthia Alexander, **CPC-A**
Cynthia Gonzalez, **CPC-A**
Cynthia Louise Leaper, **CPC-A**
Dan Gates, **CPC-A**
Darlene Salley, **CPC-A**
Dawn Alisa Fowler, **CPC-A**
Dawn Baldoni, **CPC-A**
Dawn Renee Baltimore, **CPC-A**
Deanna Loree Riedel, **CPC-A**
Deborah Driscoll, **CPC-A**
Deborah Torres, **CPC-A**
Debra Chepulis, **CPC-A**
Diane G Jungwirth, **CPC-A**
Diena M Zavetsky, **CPC-A**
Douglas Polgardy, **CPC-A**
Editha Ostil, **CPC-A**
Elizabeth Hester, **CPC-A**
Elizabeth Scheets, **CPC-A**
Elizabeth Wilson, **CPC-A**
Ellen P Catbagan, **CPC-A**
Emilie Dacanay, **CPC-A**
Erica Fross, **CPC-A**
Erin Cwanek, **CPC-A**
Eugene Rucker, **CPC-A**
Gabriele Banaszak, **CPC-A**
Gail Varner, **CPC-A**
Gina Ruys, **CPC-A**
Glenda Lester, **CPC-A**
Harmany Niemerg, **CPC-A**
Heidi Stotz, **CPC-A**
Holli Klooz, **CPC-A**
Indira Ramaswamy, **CPC-A**
Irene Tsotopoulos, **CPC-A**
Jacqualine Bobb, **CPC-A**
Jake Copeland, **CPC-A**
James C Marchbanks, **CPC-A**
Janice Little, **CPC-A**
Jarod Dain, **CPC-A**
Jean D Fitzgerald, **CPC-A**
Jeannie Lamb, **CPC-A**
Jenna Duncan, **CPC-A**
Jennifer Ann Weaver, **CPC-A**
Jennifer Marie Coyle, **CPC-A**
Jennifer Padilla, **CPC-A**
Jennifer Tlusty, **CPC-A**
Jessica Kropp, **CPC-A**
Jessica Rojas, **CPC-A**
Jessica Sproston, **CPC-A**
Jessie Lynn Skinner, **CPC-A**
Jill Torrey, **CPC-A**
Joan Corrigan, **CPC-A**
Jo Ann Anderson, **CPC-A**
Joan Pflucker, **CPC-A**
Jodi Waters, **CPC-A**
Jofelynn Alonzo, **CPC-A**
Jogy George, **CPC-A**
Joshua Ocasio, **CPC-A**
Judith Gnau, **CPC-H-A**
Julie Zagorski, **CPC-A**
Juli Gomez, **CPC-A**
Kaitlin E Kennedy, **CPC-A**
Kaitlin Leishman, **CPC-A**
Kaori Nagai, **CPC-A**
Kara Caitlin Manning, **CPC-A**
Karen Lynn Poland, **CPC-A**
Karen Marie Moore, **CPC-A**
Karin Kott, **CPC-A**
Kari Zerface, **CPC-A**
Katherine Jean Young, **CPC-A**
Kathleen Kelly, **CPC-A**
Kathryn Riley, **CPC-A**
Kathryn Smith, **CPC-A**
Kathy Moore, **CPC-A**
Kavitha Kareti, **CPC-A**
Kayla Rowe, **CPC-A**
Kelle Goshorn, **CPC-A**
Kelli Bearden, **CPC-A**
Kellie Brandt, **CPC-A**
Kellie Rice, **CPC-A**
Kelly Brandt, **CPC-A**
Kelly M Baldwin, **CPC-A**
Kelly Pardon, **CPC-A**
Kendall Richey, **CPC-A**
Kim Bennett, **CPC-A**
Kimberly Anne Shakespeare, **CPC-A**
Kimberly Byrd-Harvey, **CPC-A**
Kimberly Hawkins, **CPC-A**
Kimberly Londo, **CPC-A**
Kimberly Scriven, **CPC-A**
Kimbley Johnson, **CPC-A**
LaDonna Jean Imparato, **CPC-A**
Latarsha Fisher, **CPC-A**
Lateefah Hawthorne, **CPC-A**
Laura Raftery, **CPC-A**
Laurel Murphey, **CPC-A**
Lee Rucker, **CPC-A**
Lehana Golson, **CPC-A**
Leslie Brooke Arrants-Jordan, **CPC-A**
Linda Helmintoller, **CPC-A**
Linda Mathis, **CPC-A**
Lindsay Ireland, **CPC-A**
Lindsey Fujikawa, **CPC-A**
Lisa Lehman, **CPC-A**, CPC-H-A
Lisa M Skinner, **CPC-A**
Lora Kirkpatrick, **CPC-A**
Lori A Frame, **CPC-A**
Lori Lee Friesen, **CPC-A**
Lorna I Domitrovich, **CPC-A**
Lucy Hutmaker, **CPC-A**
Andrea Bacon, **CPC-A**
Lynne Eckert, **CPC-A**
Margie Suniga, **CPC-A**
Margo Fisher, **CPC-A**
Margo Turnage, **CPC-A**
Maria Burrows, **CPC-A**
Mariam May Harrell, **CPC-A**
Marie Corbett, **CPC-A**
Marilyn J Cordes, **CPC-A**
Marisela Ubarri, **CPC-A**
Mark Feldman, **CPC-A**
Mark Kizzee, **CPC-A**
Marsha M AuBuchon, **CPC-A**
Martha Fontana, **CPC-A**
Martha Salcedo, **CPC-A**
Mary Ann McPaul, **CPC-A**
Mary C Walsh, **CPC-A**
Mary Jean Trainor, **CPC-A**
Maura Fenlon, **CPC-A**
Meghan Brown, **CPC-A**
Melissa Fishman, **CPC-A**
Melissa S Hermanson, **CPC-A**
Michael William De Salvo, **CPC-A**
Michelle Barra, **CPC-A**
Michelle Diep, **CPC-A**
Mitch Hayner, **CPC-A**
Mitetsou Hoang, **CPC-A**
Molly Ann Belanger, **CPC-A**
Mrugesh Lala, **CPC-A**
Nancy Hennemann, **CPC-A**
Nancy Jeantel, **CPC-A**
Nancy Lasher, **CPC-A**
Nancy Marshall, **CPC-A**
Natalie Bell, **CPC-A**
Necia Austin, **CPC-A**
Nicole Lee Green, **CPC-A**
Nicole Martinez, **CPC-A**
Nicole Prince, **CPC-A**
Nina Roshon-Rabozzi, **CPC-A**
Noemi N Cox, **CPC-A**
Pamela Martin, **CPC-A**
Parshati Ray Chaudhuri, **CPC-A**
Patricia A. Galindo, **CPC-A**
Patricia Annetta Madison, **CPC-A**
Patricia A Parker, **CPC-A**
Patricia Bobbyn, **CPC-A**
Patricia Kaplan, **CPC-A**
Paula Boracki, **CPC-A**
Paula T Sandiford, **CPC-A**
Peggy Ann Dumire, **CPC-A**
Peggy Meyer, **CPC-A**
Philip Horvath, **CPC-H-A**
Phylicia Doty, **CPC-A**
Priscilla Joy Small, **CPC-A**
Raeann Bossert, **CPC-A**
Raymond Todd Gunther, **CPC-A**
Rebecca Overton, **CPC-A**
Rhonda Pierson, **CPC-A**
Rick Stringer, **CPC-A**
Robert Britchkow, **CPC-A**
Rosalyn McCarthy, **CPC-A**
Rose Marie McKinney, **CPC-A**
Rosie Divinagracia, **CPC-A**
Roxanne Betton, **CPC-A**
Ruthanne DeLucia, **CPC-A**
Sally Wheeler, **CPC-A**
Samantha Young, **CPC-A**
Sandra Meadowcroft, **CPC-A**
Sandra Zukeran, **CPC-A**
Sarah Andresen, **CPC-A**
Sarah Collins, **CPC-A**
Sasha Nicole Reif, **CPC-A**
Andrea Goodwin, **CPC-A**
Andrea John, **CPC-A**
Andrea L Carter, **CPC-A**
Andrea Moore, **CPC-A**
Andrea N'guessan, **CPC-A**
Andrea Stewart, **CPC-A**
Andrea S White, **CPC-A**
Andrea White, **CPC-A**
Angela Bernice Fields, **CPC-A**
Angela Christine Feldewerth, **CPC-A**
Angela Crossman, **CPC-A**
Angela Edwards, **CPC-A**
Angela Enoch Griffis, **CPC-A**
Angela Malave, **CPC-A**
Angela Pagano, **CPC-A**
Angela Vasquez, **CPC-A**
Angela Wheatley, **CPC-A**
Angel McKenzie Kooken, **CPC-A**
Angie Payne, **CPC-A**
Angie Wilson, **CPC-A**
Anielka Solis, **CPC-A**
Anita R Atwood, **CPC-A**
An Le, **CPC-A**
Anna Kaler, **CPC-A**
Anna Krista Van Horn, **CPC-A**
Anna Macheta, **CPC-A**
Anne Cantlon, **CPC-A**
Anne E Gaffney, **CPC-A**
Anne Opich, **CPC-A**
Anne P Shaw, **CPC-A**
Annette Bush, **CPC-A**
Ann Ferrazzo, **CPC-H-A**
Annie Tong, **CPC-A**
Ann Marie Anastasia, **CPC-H-A**
Anthony Jim, **CPC-A**
Antonia Varley, **CPC-A**
April Cahill, **CPC-A**
April Casey, **CPC-A**
April Palmer, **CPC-A**
April Schneider, **CPC-A**
Aristela Roberson, **CPC-A**
Arul Prakash Panneer Selvam, **CPC-A**
Arzu Ozmeteler, **CPC-A**
Ashlee Hammond, **CPC-A**
Ashley D Hanson, **CPC-A**
Ashley Dickerson, **CPC-A**
Ashley LaShay Handy, **CPC-A**
Ashley Lindenschmidt, **CPC-A**
Asia M Kohlbeck, **CPC-A**
Autumn Schlemmer, **CPC-A**
Baleshwar Prasad, **CPC-A**
Barbara Fregara-Michie, **CPC-A**
Barbara Peterson, **CPC-A**
Barbara Selzer, **CPC-A**
Barbara Smith, **CPC-A**
Barbara Thompson, **CPC-A**
Barbara Wood, **CPC-A**
Barbara Yeager, **CPC-A**
Bernadette Fanella, **CPC-A**
Bernadette R Tucker, **CPC-A**
Bettina Ponds, **CPC-A**
Betty Dang, **CPC-A**
Betty Spies, **CPC-A**
Beverly Delores Ivery, **CPC-A**
Beverly Harris, **CPC-A**
Beverly Turner, **CPC-A**
Bianca Elizabeth Rodriguez, **CPC-A**
Blain Zegeye, **CPC-A**
Blythe-Ann Anderson, **CPC-A**
Bonnie L Urick, **CPC-A**
Brandie Martinez, **CPC-A**
Brandine Babette Spicer, **CPC-A**
Breann Scholl, **CPC-A**
Brenda H Jones, **CPC-A**
Brenda Johnson, **CPC-A**
Brenda Lor, **CPC-A**
Brenda Parinas, **CPC-A**
Brian Polenik, **CPC-A**
Bridget Hawkins, **CPC-A**
Bridget Jones, **CPC-A**
Bridget Martin, **CPC-A**
Brittanni Sancrant, **CPC-A**
Brittany L Oliver, **CPC-A**
Brittany Patterson, **CPC-A**
Caleen Wilcox, **CPC-A**
Candace Buswell, **CPC-A**
Candace Mundy-Sillaro, **CPC-H-A**
Candice Hernandez, **CPC-A**
Candi Marie Woske, **CPC-A**
Candy Christine Cotton, **CPC-A**
Caressa Velazquez, **CPC-A**
Carla Peacock, **CPC-A**
Carly Ann White, **CPC-A**
Carmina Valdez Castro, **CPC-A**
Carol Buikema, **CPC-A**
Carol Hatfield, **CPC-A**
Carolina Montoya, **CPC-A**
Caroline H Carey, **CPC-A**

Caroline Knowlton, **CPC-A**
Carol Ratliff, **CPC-H-A**
Carol Surrao, **CPC-A**
Carol Walter, **CPC-A**
Carolyn Finch, **CPC-A**
Carolyn Walker, **CPC-A**
Carrie Ann Rogers, **CPC-A**
Carrie Henry, **CPC-A**
Carrie Lynn Moon, **CPC-A**
Carrie M. Davis, **CPC-A**
Carrie Marcum, **CPC-A**
Carrie Phipps, **CPC-A**
Carrie Von Stapleton, **CPC-A**
Caryn French, **CPC-A**
Casey Narusawa, **CPC-A**
Casey O'connell, **CPC-A**
Catherine MacLaine, **CPC-H-A**
Catherine Morrow, **CPC-A**
Catherine Vogel, **CPC-A**
Cathryn Kalista, **CPC-A**
C Terry, **CPC-A**
Cecilia Gonzalez, **CPC-A**
Chandra House, **CPC-A**
Chao Wang, **CPC-A**
Charisma Emralino, **CPC-A**
Charisse Darelin Johnson, **CPC-A**
Charles Martin, **CPC-A**
Charlotte Rochelle Scipioni, **CPC-A**
Charolette Ybarra, **CPC-A**
Chaunte D Wyche, **CPC-A**
Chenoa Ann Barnes, **CPC-A**
Cherene Grose, **CPC-A**
Cherie Cecil, **CPC-A**
Cherie M Pritchard, **CPC-A**
Cheryl Copple, **CPC-A**
Cheryl L Keene, **CPC-A**
Cheryl L Pegram, **CPC-A**
Cheryl Lynn Horning, **CPC-A**
Cheryl Motichek, **CPC-A**
Christina Gonzales, **CPC-A**
Christina Gonzalez, **CPC-A**
Christina Kuhns, **CPC-A**
Christina Miranda, **CPC-A**
Christina Shepherd, **CPC-A**
Christina Zimmerman, **CPC-A**
Christine Damm, **CPC-A**
Christine Dunlap, **CPC-A**
Christine Frances Quinones, **CPC-A**
Christine Martin, **CPC-A**
Christine Valente, **CPC-A**
Christopher Wellington, **CPC-A**
Chuck E Poore, **CPC-A**
Cindy Perkins, **CPC-A**
Cindy Williams, **CPC-A**
Claire Denise Patterson, **CPC-A**
Claire Jenkins, **CPC-A**
Claire M Daudelin, **CPC-A**
Clare T Fekkers, **CPC-A**
Claudia M Townsend, **CPC-A**
Colette Nies, **CPC-A**
Colleen Czarnecki, **CPC-A**
Connie M Bootz, **CPC-A**
Connie Rokicak, **CPC-A**
Corinne Johnson, **CPC-A**
Corinne Lanphear, **CPC-A**
Crystal Bass, **CPC-A**
Crystal Hubbard, **CPC-A**
Crystal Weis, **CPC-A**
Cynthia Ann Longman, **CPC-A**
Cynthia Bankston, **CPC-A**
Cynthia C Duat, **CPC-A**
Cynthia Duncan, **CPC-A**
Cynthia Dunlap, **CPC-A**
Cynthia Ellis, **CPC-A**
Cynthia Louise Lambert, **CPC-A**
Cynthia Lyssy, **CPC-A**
Cynthia Walker, **CPC-A**
Cynthia Yennaco, **CPC-A**
Daisy Lee Ratcliff, **CPC-A**
Dallas Calvin, **CPC-A**
Dana Phillips, **CPC-A**
Daneen Bellefeuille, **CPC-A**
Danette L McNulty, CPC-A, **CPC-H-A**
Daniel Gordon Myers, **CPC-A**
Danielle Borquist, **CPC-A**
Danielle Heeg, **CPC-A**
Danielle Renee Richard, **CPC-A**
Danielle Tereza Santillana, **CPC-A**
Dara Walsted, **CPC-A**
Darla Kay Uran, **CPC-A**
Darlene Huard, **CPC-A**
Darlene Villalon, **CPC-A**
David Lombardi, **CPC-A**
Dawn Glumicich, **CPC-A**
Dawn Gonzales, **CPC-A**
Dawn Jansen, **CPC-A**
Dawn L Hill, **CPC-A**
Dawn M Johnson, **CPC-A**
Dawn Renee Wright, **CPC-A**
Dawn Twomey, **CPC-A**
Dayana Shalomi, **CPC-A**
DeAnna Marie Forehand, **CPC-A**
Deanna Niles, **CPC-A**
Debbie Hattaway, **CPC-A**
Debbie L Hayes, **CPC-A**
Debbie Riley, **CPC-A**
Debora Fetterman, **CPC-A**
Deborah Fearon, **CPC-A**
Deborah Galiatsatos, **CPC-A**
Deborah Smith, **CPC-A**
Debra Bird, **CPC-A**
Debra Cameron, **CPC-A**
D'Andrea Hopper, **CPC-A**
Debra Carmichael, **CPC-A**
Debra Hanisch, **CPC-A**
Debra Hondorp, **CPC-A**
Debra J Schleyer, **CPC-A**
Debra L Hind, **CPC-A**
Debra McGee, **CPC-A**
Debra Overbey, **CPC-A**
Debra Polson, **CPC-A**
Deede L Billings, **CPC-A**
Deni Louise Kissel, **CPC-A**
Denise Abraham, **CPC-A**
Denise Ann Giangrosso, **CPC-A**
Denise Cicio, **CPC-A**
Denise Zebro, **CPC-A**
Dennis Martin Gonzales, **CPC-A**
Diana Mae Rousseau, **CPC-A**
Diana Santiago, **CPC-A**
Diane Frye, **CPC-A**
Diane Green-Fradin, **CPC-A**
Diane Thomaier, **CPC-A**
Dianne A Rodrigue, **CPC-A**
Dianne Cimafranca, **CPC-A**
Dipika Subash Yadav, **CPC-A**
Domenica E. Parma, **CPC-A**
Donald H Sherman, **CPC-A**
Donna Barney, **CPC-A**
Donna C Thornton, **CPC-A**
Donna Cuervo, **CPC-A**
Donna Leggett, **CPC-A**
Donna Mayer, **CPC-A**
Donna Strawn, **CPC-A**
Donna Vilagi, **CPC-A**
Donna Washington, **CPC-A**
Donna Wickerham, **CPC-A**
Donna Woosley, **CPC-A**
Donnita J Bernard, **CPC-A**
Doreen J Baltodano, **CPC-A**
Dorothy Flood-Granat, **CPC-A**
Dorothy Garland, **CPC-A**
Dorothy Schritchfield, **CPC-A**
Dusanka Mihailovic, **CPC-A**
Earl Nagle, **CPC-A**
Edith Alba, **CPC-A**
Edith Howard, **CPC-A**
Eileen Mayfield, **CPC-A**
Eileen M Brennan, **CPC-A**
Elahe Taraz, **CPC-A**
Elaine Hanley, **CPC-A**
Elaine Rink, **CPC-A**
Elisabeth C Fischer, **CPC-A**
Elizabeth Cannell, **CPC-A**
Elizabeth Eash, **CPC-A**
Elizabeth Graham, **CPC-A**
Elizabeth Henderson, **CPC-A**
Elizabeth Joanne Gardner, **CPC-A**
Elizabeth Kerr, **CPC-A**
Elizabeth Montez, **CPC-A**
Elizabeth Rodriguez, **CPC-A**
Elizabeth Rogers, **CPC-A**
Elizabeth Shoemake, **CPC-A**
Elizabeth Shope, **CPC-A**
Ella Drury, **CPC-A**
Ellen Carpenter, **CPC-A**
Ellen Patrice Martinez, **CPC-A**
Elvira Medina-Bolduc, **CPC-A**
Emelda Ibarra, **CPC-P-A**
Emilce McLarty, **CPC-A**
Emma Robertson, **CPC-A**
Erica Lynn Duerr, **CPC-A**
Erin Gibb, **CPC-A**
Erin Schiffer, **CPC-A**
Erin Witten, **CPC-A**
Evelyn Baldwin, **CPC-A**
Faustina L. Friley, **CPC-A**
Faye Lynn Sherman, **CPC-A**
Fe Maria Lopez, **CPC-A**
Fernanda Matos, **CPC-A**
Freda Bentley, **CPC-A**
Frederica Castellanos, **CPC-A**
Gail L Jones, **CPC-A**
Gail Plavets, **CPC-A**
Ganesh Brabu Sivaji, **CPC-A**
Gayatri Vilas Harmalkar, **CPC-A**
Geeta Shankarappa Magadal, **CPC-A**
Georgina Price, **CPC-A**
Gerry Reed, **CPC-A**
Geryl Herrington, **CPC-A**
Ghassan Abo-saad, **CPC-A**
Gineth Castillo, **CPC-A**
Ginger Ellis-Miller, **CPC-A**
Ginger Woodard, **CPC-A**
Gisela Ryter, **CPC-A**
Gladys Perez, **CPC-A**
Glenda Irvin, **CPC-A**
Gloria Clarkson, **CPC-A**
Gloria Harrison, **CPC-A**
Grace Donovan, **CPC-A**
Greta Simone Butler, **CPC-A**
Gretchen Elizabeth Brown, **CPC-A**
Gretchen Lee, **CPC-A**
Gwendolyn Roux, **CPC-A**
Haidy Rodriguez, **CPC-A**
Hailey Moncavage, **CPC-A**
Hannah Francis, **CPC-A**
Hayley Davis, **CPC-A**
Heather D Buckley, **CPC-A**
Heather Gene Schaefer, **CPC-A**
Heather O'Leary, **CPC-A**
Helene Kyle, **CPC-A**
Hillary Weakland, **CPC-A**
Hinal Shashikantbhai Shah, **CPC-A**
Holly Branton Byrum, **CPC-A**
Holly Creevan, **CPC-A**
Holly Hobbs, **CPC-A**
Holly Vogt, **CPC-A**
Hong Ngoc Chau, **CPC-A**
Ibis A Montijo MD, **CPC-A**
Ines Perez, **CPC-A**
Ivette DeJesus, **CPC-A**
Izabela Wroblewski, **CPC-A**
Jack Michael Stiefel, **CPC-A**
Jacqueline Millerd, **CPC-A**
Jacqueline Ramirez, **CPC-A**
Jaime Bell, **CPC-A**
Jaime Cote, **CPC-P-A**
Jaime Cupps, **CPC-A**
James Bogert, **CPC-A**
James Defillippo, **CPC-A**
James John Pacifico, **CPC-A**
Jamie Ackerman, **CPC-A**
Jamie Gray, **CPC-A**
Jamie Livingston, **CPC-A**
Jane Dean, **CPC-A**
Jane M Rocheleau, **CPC-A**
Jane Shields-Johnson, **CPC-A**
Janet Ann Kellogg, **CPC-A**
Janet Davis, **CPC-A**
Janet Fuller, **CPC-A**
Janet Kolousek, **CPC-A**
Janice Moore Stevenson, **CPC-A**
Janice M Spaulding, **CPC-A**
Janice Rasmussen, **CPC-A**
Janice Thompson, **CPC-A**
Janice Ulmer, **CPC-A**
Janis Andrews, **CPC-A**
Jasmin Q. Tan, **CPC-A**
Jason Farmer, **CPC-A**
Jean Elizabeth Russell, **CPC-A**
Jeanie Byrd, **CPC-A**
Jeanne Ann Carver, **CPC-A**
Jeanne P Gates, **CPC-A**
Jeanne Sandler, **CPC-A**
Jeannie Brinkey, **CPC-A**
Jeannie Harp, **CPC-A**
Jeannie Mari Morgan, **CPC-A**, CPC-H-A
Jeannine Del Bene, **CPC-A**
Jeannine Hilb, **CPC-A**
Jeffrey Stone, **CPC-A**
Jenifer Zawadowski, **CPC-A**
Jennielyn R Quilizapa, **CPC-A**
Jennifer Bates, **CPC-A**
Jennifer Bauman, **CPC-A**
Jennifer Cleary, **CPC-A**
Jennifer Coleman, **CPC-A**
Jennifer Cunningham, **CPC-A**
Jennifer Kniffen, **CPC-A**
Jennifer Lynn Kirk, **CPC-A**
Jennifer Lynn Nguyen, **CPC-A**
Jennifer Mata, **CPC-A**
Jennifer M Meisel, **CPC-A**
Jennifer Rhodes, **CPC-A**
Jennifer Russell, **CPC-A**
Jennifer Schlander, **CPC-A**
Jennifer Shults, **CPC-A**
Jennifer Wrobel, **CPC-A**
Jenny M Davis, **CPC-A**
Jenny Wright, **CPC-A**
Jessica Armstrong, **CPC-A**
Jessica Fernandez-Reed, **CPC-A**
Jessica Hicks, **CPC-A**
Jessica LaToya Mayes, **CPC-A**
Jessica LeGrande, **CPC-A**
Jessica Leide, **CPC-A**
Jessica Torres, **CPC-A**
Jijimon John, **CPC-A**
Joan Carr, **CPC-A**
Joanna Lynn Ross, **CPC-A**
Joann Donati, **CPC-A**
Joanne Baffic, **CPC-A**
Joanne Douglas, **CPC-A**
Joann Highsmith, **CPC-A**
Jodie Gormley, **CPC-A**
Joell Keim, **CPC-A**
JoeNeth Gabriel, **CPC-A**
John A Greulich, **CPC-A**
John Meyer, **CPC-A**
Jonathan Gaines, **CPC-A**
Joohee Jung, **CPC-A**
Joscelyn Chan, **CPC-A**
Joseph Nicholas Gutierrez, **CPC-A**
Josette Joseph, **CPC-A**
Joshua Longberry, **CPC-A**
Joy Goodlow, **CPC-A**
Joy Ruland, **CPC-A**
Judith Ann Harris, **CPC-A**
Judith Parker, **CPC-A**
Judith Stapleton, **CPC-A**
Judy Garringer, **CPC-A**
Judy Haynes, **CPC-A**
Judy Shamblin, **CPC-A**
Julia Diane Crawford, **CPC-A**
Juliana Barrows, **CPC-A**
Julie Brummitt, **CPC-A**
Julie Burgess, **CPC-A**
Julie Gilstrap, **CPC-A**
Julie Hill, **CPC-A**
Julie Newton, **CPC-A**
Julie Wilson, **CPC-A**
June Buscemi, **CPC-A**
Justin Garcia, **CPC-A**
Kalaiyarasan Madasamy, **CPC-A**
Kalpana Fotedar, **CPC-A**, CPC-H-A
Kanagavalli C, **CPC-A**
Kara Jane Kick, **CPC-A**
Kara Kimmel, **CPC-A**
Karen Bowman, **CPC-A**
Karen Darnell, **CPC-A**
Karen Hammer, **CPC-A**
Karen I Wiley, **CPC-A**
Karen Lombard, **CPC-A**
Karen Love, **CPC-A**
Karen Pierson, **CPC-A**
Karen Ramos, **CPC-A**
Karen Rich-Smith, **CPC-A**
Kari Morin, **CPC-A**
Kari R Gingell, **CPC-A**
Karly D Lawson, **CPC-A**
Karthikeyani Subramanian, **CPC-A**
Kassandra Bialy, **CPC-A**
Katherine Datner Wood, **CPC-A**
Katherine F Hayes, **CPC-A**
Kathie Gray, **CPC-A**
Kathleen Dennis, **CPC-A**
Kathleen Kelly, **CPC-A**
Kathleen M Alden, **CPC-A**
Kathleen Serek, **CPC-A**
Kathleen Tipton, **CPC-A**
Kathryn I Miles, CPC-A, **CPC-H-A**
Kathryn M Miller, **CPC-A**
Kathryn O'Neal, **CPC-A**
Kathryn Sue Kamm, **CPC-A**
Kathy Burch, **CPC-A**
Kathy Cavender, **CPC-A**
Kathy D Waddell, **CPC-A**
Kathy J Owili, **CPC-A**
Kathy Turner, **CPC-A**
Katie Clark, **CPC-A**
Katie Landowski, **CPC-A**
Katie Walker, **CPC-A**
Kavitha Sampath, **CPC-A**
Kawell Soto, **CPC-A**
Kay Brown, **CPC-A**
Kay Sheri Suitter, **CPC-A**
Keely Mcclanahan, **CPC-A**
Kelley Ann Haynes, **CPC-A**
Kellie Keiser, **CPC-A**
Kelly K O'Connell, **CPC-A**
Kelly Owens, **CPC-A**
Kelly R Kelsey, **CPC-A**
Kelly Robin Stanley, **CPC-A**
Kelly Wilder, **CPC-A**
Kelsi Scott Cheek, **CPC-A**
Kenisha V Myhand, **CPC-A**
Kerri Rutkowski, **CPC-A**
Kerry Moberly-Pratt, **CPC-A**
Kimberley A Hopper, **CPC-A**
Kimberly Adams, **CPC-A**
Kimberly Brown, **CPC-A**
Kimberly Brown, **CPC-A**
Kimberly Gomez, **CPC-A**
Kimberly Jackson, **CPC-A**
Kimberly Janin Torres, **CPC-A**
Kimberly Jean Downey, **CPC-A**
Kimberly Krenza, **CPC-A**
Kimberly Lee, **CPC-A**
Kimberly Mai, **CPC-A**
Kimberly Olivares, **CPC-A**
Kim Marie Weiser, **CPC-A**
Kim M Harding, **CPC-A**
Kim Mielkus, **CPC-A**
Kim Steinke, **CPC-A**
Kirsten Nicole Brown, **CPC-A**
Kris Gloeckl, **CPC-H-A**
Krisha Daugherty, **CPC-A**
Kristen Camelio, **CPC-A**
Kristen Werme, **CPC-A**
Kristie Williams, **CPC-A**
Kristina Ramsay, **CPC-A**
Kristin Bailey, **CPC-A**
Kristin Walker, **CPC-A**
Kristy Meservy, **CPC-A**
Krystle Hence, **CPC-A**
Lacey Wilson, **CPC-A**
Lakeisha Jenelle Chapman, **CPC-A**
Lara Madalyn Carlton, **CPC-A**
Laren Del Reyes Richards, **CPC-A**
LaShonda Renee Yocum, CPC-A, **CPC-H-A**
Laura Aurelio, **CPC-A**
Laura Barlow, **CPC-A**
Laura Fox, **CPC-A**
Laura Marie Frank, **CPC-A**
Laura Pierson, **CPC-A**
Laura Witherspoon, **CPC-A**
Laurie Hieter, **CPC-A**
Laurie Lea Kimball, **CPC-A**
Lauri Stumpf, **CPC-A**
Leah Mae Parmenter, **CPC-A**
Leah Pech, **CPC-A**
Lea Hughes, **CPC-A**
Leeann Yurchenko, **CPC-A**
Lee Z Chichester, **CPC-A**
Leslie Creasea, **CPC-A**
Leslie Ormsby, **CPC-A**
Leyla Kimzey, **CPC-A**
Lily Shack, **CPC-A**
Linda Aucoin, **CPC-A**
Linda Bradley, **CPC-A**
Linda Buchs, **CPC-A**
Linda Foster, **CPC-A**
Linda H Min, **CPC-A**
Linda Jeffreys, **CPC-A**
Linda Mattran, **CPC-A**
Linda Myers, **CPC-A**
Linda Rumble, **CPC-A**
Linda Salter, **CPC-A**
Linda Sue Johnson, **CPC-A**
Linda Tang, **CPC-A**
Linda Walleman, **CPC-A**
Lisa Altimari, **CPC-A**
Lisa A Pauley, **CPC-A**
Lisa Beslic, **CPC-A**
Lisa Blawusch, **CPC-A**
Lisa Clover, **CPC-A**
Lisa Dantzer, **CPC-A**
Lisa D Brooks, **CPC-A**
Lisa Filippone, **CPC-A**
Lisa H. S. Song, **CPC-A**

Lisa Kimbrough, **CPC-A**
Lisa K Mielbrecht, **CPC-A**
Lisa Larson, **CPC-A**
Lisa Marie Green, **CPC-A**
Lisa M Bobrow, **CPC-A**
Lisa Nightenhelser, **CPC-A**
Lisa Piper, **CPC-A**
Lisa Renfro-Nelson, **CPC-A**
Lisa Schwartz, **CPC-A**
Lisa Sherrin Margolin, **CPC-A**
Lisa Tatiana Sanford, **CPC-A**
Lisa Thomas, **CPC-A**
Lissette Cantu, **CPC-A**
Liz Embert, **CPC-A**
Lora Ann Wasson, **CPC-A**
Loretta Whitaker, **CPC-A**
Lorie Reagle, **CPC-A**
Lori Hartley, **CPC-A**, CPC-H-A
Lori Overmyer, **CPC-A**
Lori Pavidis, **CPC-A**
Lori Roberts, **CPC-A**
Lorraine Lukes Heckman, **CPC-A**
Lorraine Marie Butin, **CPC-A**
Lou Ann Faulkner, **CPC-A**
Loucinda McCalla, **CPC-A**
Lourdes V Beltran, **CPC-A**
LuAnn Jacob, **CPC-A**
LU Zhang, **CPC-A**
Lydia Barbely, **CPC-A**
Lynda Jo Rinaldi, **CPC-A**
Lynette Jones, **CPC-A**
Lynn Johnson, **CPC-A**
Mable Flynn, **CPC-A**
Machonne Barlow, **CPC-A**
Madeline Illa, **CPC-A**
Madeline Latislaw, **CPC-A**
Malana Skolnick, **CPC-A**
MaLinda Teboe, **CPC-A**
Manisha Chowdhury, **CPC-A**
Marcela Acevedo, **CPC-A**
Marci C Schuster, **CPC-A**
Margaret Markowski, **CPC-A**
Margaret Schiedler, **CPC-A**
Margaret Wright, **CPC-A**
Maria Alderson, **CPC-A**
Maria Imelda Alvarez, **CPC-A**
Maria Kuzyakina, **CPC-A**
Maria Ladner, **CPC-A**
Maria Nazeir Rophaiel, **CPC-A**
Marianne Frate, **CPC-A**
Marie Catherine Redlecki, **CPC-A**
Marie Sullens, **CPC-A**
Mariliz Suarez, **CPC-A**
Mario Bien-Aime, **CPC-A**
Mario Carbone, **CPC-H-A**
Marion Snyder, **CPC-A**
Mark Allan Fernandez, **CPC-A**
Mark Mayo, **CPC-A**
Marlon Mclean, **CPC-A**
Marsha Hoo, **CPC-A**
Martha Gillam, **CPC-A**
Marvia L Davis, **CPC-A**
Mary Alexander, **CPC-A**
Mary Ann Smith, **CPC-A**
Mary Baldon, **CPC-A**
Mary Beth Przychocki, **CPC-A**
Mary Carol Bitz, **CPC-A**
Mary Cooper Ayd, **CPC-A**
Mary Doyle, **CPC-A**
Mary Frances Newsom, **CPC-A**
Mary Green, **CPC-A**
Mary L Hogan, **CPC-A Mary L Walsh**, CPC-A
Mary Madden, **CPC-A**
Mary Markowski, **CPC-A**
Masami Malaowala, **CPC-A**
Matthew James Cannon, **CPC-A**
Matthew Scott Snow, **CPC-A**
Matthew Toniatti, **CPC-A**
Maybelline Plandor Reyes, **CPC-A**
Megan Baez, **CPC-A**
Megan Willett, **CPC-A**
Melanie D Davis, **CPC-A**
Melanie Layton, **CPC-A**
Melanie Mercer, **CPC-A**
Melissa Ann Mitchell, **CPC-A**
Melissa Hills, **CPC-A**
Melissa Insisiengmay Hendry, **CPC-A**
Melissa Nicole Hammond, **CPC-A**
Melissa Petty, **CPC-A**
Melissa Taylor, **CPC-A**
Melody Hassell, **CPC-A**
Melody Jo Patrick, **CPC-A**
Meriele Martinez, **CPC-A**
Mesha Denae Johnson, **CPC-A**
Michael Farrell, **CPC-A**
Michael Kweku Ekpeh, **CPC-A**
Michele Houghton, **CPC-A**
Michele Melsha, **CPC-A**
Michele Petterson, **CPC-A**
Michele Ralston, **CPC-A**
Michelle Bradford, **CPC-A**
Michelle Butler, **CPC-A**
Michelle Domingo, **CPC-A**
Michelle Goldsmith, **CPC-A**
Michelle Lee McTigue, **CPC-A**
Michelle McCombs, **CPC-A**
Michelle Ruelas, **CPC-A**
Michelle Sergei-Casiano, **CPC-A**
Michelle Treers, **CPC-A**
Mihaela O'Dell, **CPC-A**
Mikal Gadley, **CPC-A**
Minal Gajanan Sarate, **CPC-A**
Mindy Barger, **CPC-A**
Mindy J Schimpf, **CPC-A**
Mindy Wright, **CPC-A**
Miranda Nelson Knox, **CPC-A**
Misty Bruhn, **CPC-A**
Monica A Lavergne Draz, **CPC-A**
Monica Lynn Shartzer, **CPC-A**
Monica Masterson, **CPC-A**
Moon Chanh Doungchack, **CPC-A**
Munif Rabadi, **CPC-A**
Myra Denice Hill, **CPC-A**
Nalini Sukhoo, **CPC-A**
Namrata Narayan Balgude, **CPC-A**
Nancy Collins, **CPC-A**
Nancy Galindo, **CPC-A**
Nancy Glover, **CPC-A**
Nancy Pollock, **CPC-A**
Nancy Reinertsen, **CPC-A**
Naomi N Fukuda, **CPC-A**
Natalie Towner, **CPC-A**
Natasha Coppedge, **CPC-A**
Nicholas Albert Tedeschi, **CPC-A**
Nicolas Anthony Nelken, **CPC-A**
Nicole Adelberg, **CPC-A**
Nicole Knight, **CPC-A**
Nicole Kollmorgen, **CPC-A**
Nicole M Galinis, **CPC-A**
Nicole Trump, **CPC-A**
Nikki C Hardy, **CPC-A**
Nilsa Ocasio, **CPC-A**
Noelle Magrath, **CPC-A**
Ololade Odunjo, **CPC-A**
Ornella Elizabeth Singh, **CPC-A**
Osha Pruitt, **CPC-A**
Paige Fuller, **CPC-A**
Paige Sipula, **CPC-A**
Pamela Anne Whitney, **CPC-A**
Pamela Ann Jensen, **CPC-A**
Pamela D Crawford, **CPC-A**
Pamela Jo Schultz, **CPC-A**
Pamela L. Tucker, **CPC-A**
Pamela Lynn Sturgeon, **CPC-A**
Pamela M Cook, **CPC-A**
Pamela Pitts, **CPC-A**
Pamela Prashad Budhoo, **CPC-A**
Pamela Rodgers, **CPC-A**
Pam Hanna, **CPC-A**
Pandian Elumalai, **CPC-A**
Pandy Baughcum, **CPC-A**
Patricia Aguiar, **CPC-A**
Patricia Ann Miller, **CPC-A**
Patricia Ann Welch, **CPC-A**
Patricia Conquest, **CPC-A**
Patricia Crowley, **CPC-A**
Patricia Dindia, **CPC-A**
Patricia Furtado, **CPC-A**
Patricia Giada Earl, **CPC-A**
Patricia Johnson, **CPC-A**
Patricia M. Damiani, **CPC-A**
Patricia Schoen, **CPC-A**
Patti Walker, **CPC-A**
Paula F Onoff, **CPC-A**
Paula Mounts, **CPC-A**
Paul Goodsaid, **CPC-A**
Peggy Pierman, CPC-A, **CPC-H-A**
Philip Daniel Lee, **CPC-A**
Phoua K Vang, **CPC-A**
Phyllis A Carter, **CPC-A**
Pornsawan Kanpakdee, **CPC-A**
Pragati Vijay Nanarkar, **CPC-A**
Prakash Durairaju, **CPC-A**
Pratheep Kumar Rawlinson, **CPC-A**
Queenetta Adams, **CPC-A**
Rachel Ecker, **CPC-A**
Rachel Jones, **CPC-A**
Rachel J Winters, **CPC-A**
Rachel Tonkin, **CPC-A**
RaeAnn Vizina, **CPC-A**
Rafael L Cepeda, **CPC-A**
Rajesh Jeganathan, **CPC-A**
Raj Kataria, **CPC-A**
Rajna Arora, **CPC-A**
Ramona Smith, **CPC-A**
Ravichandran Rajasekaran, **CPC-A**
Raymond M. Kinscy, **CPC-A**
Rebecca Ann Bishop, **CPC-A**
Rebecca Jean Cameron, **CPC-A**
Rebecca L Eagan, **CPC-A**
Rebecca Webb, **CPC-A**
ReGina Ford, **CPC-A**
Renae Anderson, **CPC-A**
Rena Sparks, **CPC-A**
Renee Brown, **CPC-A**
Renee Potter, **CPC-A**
Rhionna Sanderson, **CPC-A**
Rhomin Tengco, **CPC-A**
Rhonda Michelle Ishmael, **CPC-A**
Rhonda Parker, **CPC-A**
Richard C Winkfield, **CPC-A**
Rita T Reyes, **CPC-A**
Rizwan Ali, **CPC-A**
Roberta Bernier, **CPC-A**
Robert Strenk, **CPC-A**
Robin Elaine Shemendera, **CPC-A**
Robin E Purto, **CPC-A**
Robin L DeRosa, **CPC-A**
Robyn Curtis, **CPC-A**
Rodica Moga, CPC-A, **CPC-H-A**
Roma Lala, **CPC-A**
Ronald W Parent, **CPC-A**
Rosalie Espiritu-Foster, **CPC-A**
Rosa Maria Lopez, **CPC-A**
Rosemary Anne Burd, **CPC-A**
Rossana Schachter, **CPC-A**
Roy Seraos Tuvilla, **CPC-A**
Ruby K Camarena, **CPC-A**
Ruby Petty, **CPC-A**
Russell Ryan, **CPC-A**
Ruth Diane Piper, **CPC-A**
Sadie Freerksen, **CPC-A**
Saeed Akhtar, **CPC-A**
Sakthivel Suresh Kumar, **CPC-A**
Salena Poplin, **CPC-A**
Salini Chandran, **CPC-A**
Samantha Brown, **CPC-A**
Samantha G Ballard, **CPC-A**
Samuel Jiwanmall, **CPC-A**
Sandra Alba, **CPC-A**
Sandra Cope, **CPC-A**
Sandra Fischer, **CPC-A**
Sandra L Villa, **CPC-A**
Sandra Lynn Enfield, **CPC-A**
Sandra Moore, **CPC-A**
Sandra Rue RN, **CPC-A**
Santhiya Madhurai, **CPC-A**
Sara Boland, **CPC-A**
Sarah Chichester, **CPC-A**
Sarah Durst, **CPC-A**
Sarah Frasier, **CPC-A**
Sarah Holmes, **CPC-A**
Sarah Sedor, **CPC-A**
Sarah Suber, **CPC-A**
Sarah Younger, **CPC-A**
Saul Granados, **CPC-A**
Sayquon T Keys, **CPC-H-A**
Scarlette Austin, **CPC-A**
Scott Hendren, **CPC-A**
Sean Sohl, **CPC-A**
Sekar Mahalakshmi, **CPC-A**
Selina Ferguson, **CPC-A**
Semije Odza, **CPC-A**
Sequita Mitchell, **CPC-A**
Shaina Britt, **CPC-A**
Shajahan Jamaludeen, **CPC-A**
Shamaila Hussain, **CPC-A**
Shannon Jeffcoat, **CPC-A**
Shannon Shanks, **CPC-A**
Shaquana Shonta Moore, **CPC-A**
Sharmaine Shante Washington, **CPC-A**
Sharmila Banu Jamal Mohamed, **CPC-A**
Sharon Hittle, **CPC-A**
Sharon Holzmeyer, **CPC-A**
Sharon Krolczyk, **CPC-A**
Sharon Sikorski, **CPC-A**
Shawn Johnson, **CPC-A**
Shawn N Fee, **CPC-A**
Sheena Corley, **CPC-A**
Sheila Gulledge, **CPC-A**
Sheila Rae Miskell, **CPC-A**
Sheila T Davis, **CPC-A**
Shelby Brown, **CPC-A**
Sheldon Lutz, **CPC-A**
Shelia Hoefer, **CPC-A**
Shelley Blumberg, **CPC-A**
Shelley Qualls, **CPC-A**
Shelly Barkley, **CPC-A**
Sheneika Green, **CPC-A**
Sherie Nicole Bradley, **CPC-A**
Sherilyn Lou Burdick, **CPC-A**
Sherrell Cauley, **CPC-A**
Sherria Lyna Heath, **CPC-A**
Sherri Blatt, **CPC-A**
Sherry Hutchins, **CPC-A**
Sherry L VanTassel, **CPC-A**
Sheryl Carter, **CPC-A**
Sheryl McVaigh, **CPC-A**
Shirley J Brown, **CPC-A**
Shymshun Ali, **CPC-A**
Sierra Lee Baum, **CPC-A**
Sonia Hernandez, **CPC-A**
Sonya Denise Kohl, **CPC-A**
Sonya Gibbons, **CPC-A**
Sonya Yvette Francis, **CPC-A**
Stacey Andrews, **CPC-A**
Staceyann Simone Fletcher, **CPC-A**
Stacey Clark, **CPC-A**
Stacey Oare, **CPC-A**
Stacie Tackett, **CPC-A**
Stacy Clark, **CPC-A**
Stacy Kimberling, **CPC-A**
Stacy Lynn Auten, **CPC-A**
Stacy Swanberry, **CPC-A**
Stephanie Anna Zangla, **CPC-A**
Stephanie Brooks, **CPC-H-A**
Stephanie Chapman, **CPC-A**
Stephanie Cohen, **CPC-A**
Stephanie Hutchison, **CPC-A**
Stephanie Perkins, **CPC-A**
Stephanie Smith, **CPC-A**
Stephanie Webber, **CPC-A**
Stephany Robledo, **CPC-A**
Stephen Cassidy, **CPC-A**
Sucharita Kakuturu, **CPC-A**
Sue Ann Huss, **CPC-A**
Sumeet G Lawhare, **CPC-A**
Summer Dawn Garner, **CPC-A**
Summer Hestad, **CPC-A**
Susan Afiri, **CPC-A**
Susan Chvatal, **CPC-A**
Susan Garland, **CPC-A**
Susan Hascall, **CPC-A**
Susan J Demetris, **CPC-A**
Susan L Kelly, **CPC-A**
Susan Norton, **CPC-A**
Susan Pellerin, **CPC-A**
Susan Peter Eapen, **CPC-A**
Susan Shepard, **CPC-A**
Susan S Tobey, **CPC-A**
Susan Wagner, **CPC-A**
Suzanna C Farley, **CPC-A**
Suzanne Forbes, **CPC-A**
Suzanne L Mucha, CPC-A, **CPC-H-A**, CPMA
Swathi Praveen, **CPC-A**
Sylvia Santos, **CPC-A**
Tabatha Navarro, **CPC-A**
Tabetha M Dunn, **CPC-A**
Tahnee Mose, **CPC-A**
Takeema Muller, **CPC-A**
Tammy Call, **CPC-A**
Tammy Eggers, **CPC-A**
Tammy Klotzer, **CPC-A**
Tammy Rae Garmon, **CPC-A**
Tammy Shelton, **CPC-A**
Tanya Lea Wollner, **CPC-A**
Taryn Jacobus, **CPC-A**
Tasheva Nicole Watson, **CPC-A**
Taunisha M Clinkscale, **CPC-A**
Teisha Bond, **CPC-A**
Teresa Ann Golden, **CPC-A**
Teresa Freymuth, **CPC-A**
Teresa Herrig, **CPC-A**
Teresa Lynn Crittenden, **CPC-A**
Teresa Nelson, **CPC-A**
Terri Coats, **CPC-A**
Theresa Gagliardo, **CPC-A**
Theresa Lashway, **CPC-A**
Theresa Levin, **CPC-A**
Theresa Mcdonald, **CPC-A**
Theresa M Smith, **CPC-A**
Theresa Schnabel, **CPC-A**
Therese L Fournier, **CPC-A**
Therese L Genia, **CPC-A**
Thooyamani Chitrarasu, **CPC-A**
Tia M Jones, **CPC-A**
Tia M Thornton, **CPC-A**
Tiffany Anne Mick, **CPC-A**
Tiffany Ann Kronjak, **CPC-A**
Tiffany Wilborn, **CPC-A**
Timothy James Chatas II, **CPC-A**
Tina Garno, **CPC-A**
Tina Marie Peet, **CPC-A**
Tina Peluso, **CPC-A**
Tina Ruby, **CPC-A**
Tobetria Moneque Strong, **CPC-A**
Tonianne Genovese, **CPC-A**
Toni Rosales, **CPC-A**
Tonya Lynn McCoy, **CPC-A**
Tonya Michelle Anderson, **CPC-A**
Tonya Twomey, CPC-A, **CPC-H-A**
Tori Miller, **CPC-H-A**
Tracey Norris, **CPC-A**
Tracie Hardin, **CPC-A**
Tracy Anne Jones, **CPC-A**
Tracy Cornett, **CPC-A**
Tricia Weitz, **CPC-A**
Trina Alachnowicz, **CPC-A**
Trudy Hight, **CPC-A**
Tyra Daniel, **CPC-A**
Urmi Uday Biswas, **CPC-A**
Valerie Amber Dela Cruz, **CPC-A**
Vanessa L Martin, **CPC-A**
Veronica Burrows, **CPC-A**
Veronica Litterio, **CPC-A**
Veronica Moore, **CPC-A**
Vibha Das, **CPC-A**
Vickie Hause, **CPC-A**
Vicki Elliott, **CPC-A**
Vickie Padilla, **CPC-A**
Vicki Hintz, **CPC-A**
Vicki K Clark, **CPC-A**
Vicky Gower, **CPC-A**
Victoria DeSalvo, **CPC-A**
Victor Montejo, **CPC-A**
Vidya Ananda Harer, **CPC-A**
Vilma Vittekova Beck, **CPC-A**
Virginia Peek, **CPC-A**
Vivian Webb, **CPC-A**
Wanda Kay Braswell, **CPC-A**
Wayne Wesley Minick, **CPC-A**
Wenda Holman, **CPC-A**
Wendy Newcomb, **CPC-A**
Whitney Burris, **CPC-A**
Whitney Kusy, **CPC-A**
William Maxwell, **CPC-A**
William Welsh, **CPC-A**
Xuejiao Chen, **CPC-A**
Yayoi Tokuhara, **CPC-A**
Yoandra Tito, **CPC-A**
Yoni D Huaco, **CPC-A**
Yue Qu, **CPC-A**
Yuhjen Dai, **CPC-A**
Yvette Peralta, **CPC-A**
Zehra Qasim, **CPC-A**

Specialties

Adrienne Zarn, CPC, **CANPC**
Aida Pena, **CANPC**
Aleta Lynn Sumrall, **CPC**, CPC-H, **CIMC**
Alice M Salcido, CPC, **CEDC**
Allison D Grant, CPC, **COSC**
Amii Nicole Linder, CPC, **CPMA**
Amy Guhr, **CPC**, CEMC, **COSC**
Ana Liza M Cruz, **CPC**, CPMA, CEMC
Anastasia Walle, CPC-A, **CGIC**
Angela Boyd, **CPEDC**
Angela Margaret Hickman, CPC, **CEDC**
Annette M Schaffter, CPC-A, **CEDC**
Barbara A McGann, CPC, **COSC**
Barbara J Guenterberg, CPC-A, **CEDC**
Barbara Jean O'Connor, CPC, **CEDC**, CEMC
Becky Mora, **CRHC**
Belinda B Shannon, CPC, **CPRC**
Bernadette C Alferez, CPC-A, **CGSC**
Beverly Gudgel, CPC, **CIRCC**, CCC
Bill N Cox Jr, CPC, **CPMA**
Brandi Nicole Watts, CPC, **COSC**
Candi Hume, CPC, **CIRCC**
Cara Detlefsen, **CGSC**
Carla Ann Wallace, CPC, **CFPC**
Carol Boesel, CPC, **CPMA**

Cary P Bailey, **COBGC**
Cassandra Marie Romero, CPC, **CPMA**, CEMC
Chanda Gamble, **CEDC**
Charlene N Miller, CPC, CCC, CGIC, **COBGC**
Cristina Van Elgort, CPC, **CPMA**
Christy Heffernan, CPC, **CENTC**
Cori Rocks, CPC-A, **CFPC**
Cristen Campini, CPC, **CIRCC**
Crystal DeMario, CPC, **CIRCC**
Cynthia Jane Steedman, CPC, **CPMA**
Dan Robinson, **CGIC**
Dana J Smith, **CEDC**
Dara Grieger, **CIRCC**
Deann Tate, CPC, **CPMA**, CEMC
Deanna Blalock-Polley, CPC, **COSC**
Deborah K McConnell, CPC, **CGIC**
Denice Hogan, CPC, **CPMA**
Desiree P Holliman, **CEDC**
Diana G Wilson, CPC, **CPMA**, CPC-I
Diane Crosthwaite, **CPC**, CANPC
Diane S Elsey, **CRHC**
Donna Kathryn Sheckter, CPC, **CPMA**
Dorian F Rozier, CPC, **CPMA**
Dusty Lindsey, **CANPC**
Edith Kay Hall, CPC, **CPMA**
Edward Leone, CPC, **COSC**
Frances Fisher, CRHC
G. Elizabeth Wilson, **CEMC**
Gina F Taylor, CPC, **CPMA**, COBGC
Gina Patricia Holdorff, CPC, CPC-H, CPC-P, **CPMA**, CHONC
Ginell Wetter, **CPCD**
Gloria M Moulton, CPC, CPC-H, **CPMA**
Harriet Graver-Hoover, CPC, **CRHC**
Hermione Elam, CPC, **CPMA**
Irina Veron, CPC, **CGIC**
Jacqueline Brown, **COBGC**
James Cotton, CPC, **CEMC**, CGIC
Janet E Werling, CPC, **CGSC**
Janine Michelle Wackowski, **CEMC**
Jeannett Diestro, CPC-A, **CASCC**
Jennifer Rene Moore, CPC, **CPMA**
Jessica Acosta, CPC, **CPMA**
Jessica Driver-Zuniga, CPC, **CEMC**
Jessica Lynn Boes, CPC, **CPMA**
Jill Engle, **CPCD**
Jill Whittamore, CPC, **CPMA**
Jill Ann Marie, CPC, **CGSC**
JoAnn Skrzypek, CPC, **CEMC**
Joanna Soucek, CPC, **CANPC**
Joanne Lee Ortolan, **CPMA**
Jodi DiBiasi, CPC, **CPMA**
Jodie L Mattern, **CIMC**
Johanna Kratt, CPC, **CPMA**
John Mark Young, CPC, **CPCO**
Jolean Boutwell, CPC, **CHONC**
Karen Acton, **COBGC**
Karen Caporale, **CPC**, COSC
Karen M Fancher, MD, CPC, **CANPC**, CFPC
Karla D Stillwell, CPC, **CPMA**
Kathy Hall Leap, CPC, CPC-H, **CEMC**
Katrina Gunter, **CEDC**
Kea D Gaddis, **CRHC**
Kelly Mayumi George, CPC, **CUC**
Kerri Russell, CPC, **COSC**
KeSha Johnson-Mayes, **CFPC**
Kim S Neraasen, CPC, **CFPC**
Kim Rachel Vo, CPC, **CIRCC**
Kimberly Dickerson, CPC, **CPCO**
Kimberly R Pizzo, CPC, **CPMA**
Laura Salazar, CPC-A, **CPMA**
Lance Smith, **CEMC**
Laura Greco, **CPMA**
Laurie Verellen, **CEMC**
Lee Ann Atkinson, CPC, **CANPC**
Leila Ganthier, CPC, CPC-H, **CPMA**
Leona Mary Kiamahoe, CPC, CPC-H, CPC-P, **CPMA**
Lisa M Kropp, CPC, **CPMA**
Lori A Doll, CPC, **CPMA**
Mallory Espejo, CPC, **CPCD**
Margaret P Leacock, CPC, **CPMA**
Maria A Candia, CPC, **CPC-H**, **CPMA**, CEMC
Maria Elena Maldonado, CPC, **CPC-H**, **CPCO**, CPMA, CEDC, CEMC
Marilyn Callahan, MCS-P, CPC, **CPMA**
Marla Sue Christensen, CPC, **CANPC**
Marlyn Ramirez, CPC, **CPMA**
Mary E Horner, CPC, CPC-H, **CIRCC**, CPC-I
Maryann F Crouch, CPC, **CEMC**
Maryellen F Hulwick, CPC, **CPMA**
Melissa Marie Outman, CPC, **CPMA**
Melissa Ruediger, CPC, **CPMA**
Melody S Irvine, CPC, CPMA, CPC-I, CEMC, **CFPC**
Michael Ann Fowler, CPC, **CPMA**
Michelle Yvonne Miller, CPC, **CEDC**
Michael Hideo Nomura, CPC, CPC-H, CPC-P, **CEDC**
Michelle Nicole Stech, CPC, **COSC**
Michelle Silveira, **CEDC**
Michelle Stepp, CPC, **CPMA**
Michelle A Trandel, CPC, **CFPC**
Minaxi M Patel, **CPMA**
Mitzie Dunkley, CPC, **CEMC**
Nancy Baning, CPC, CCC, **CEMC**
Nancy E Gard, CPC, **CPMA**, COBGC
Nicole Colbenson, **CANPC**
Nicole Marie Ogren, **CRHC**
Nural Ergun, CPC, **CIRCC**
Pamela B Miller, CPC, **CPMA**
Patricia Diane Nelson, CPC, **CEDC**
Paula Papp, CPC, **CPMA**
Peter Davidyock, CPC, **CPMA**
Raechel K Zamarripa, CPC, **CIRCC**
Randee Herner, CPC, **CEMC**
Rebecca Hurley, CPC, **CPCO**
Rebecca Lassiter, **CIRCC**
Rebekah Helan Mortimore, CPC-A, **CFPC**
Richard Lance Cummins, CPC, **CPMA**
Ross Kerievsky, CPC, **CPMA**
Roxanna Menger, CPC, **CPMA**, CEMC
Sandra Dohlman, CPC-H, **COBGC**
Sandra Thomas, CPC, **CFPC**
Sarah J Carpenter, CPC, **CCC**
Sarah Ross, **CEMC**
Sharee Luckeydoo, CPC, CPC-H, **CPCO**, CANPC, CEDC
Sharon Kiessling, CPC, **CEMC**
Sheisa Seda, CPC, **COBGC**
Shirley V Porns, CPC, **CPMA**
Socorro Nacasabog Nalley, CPC, **CPMA**
Sonya Harmon, CPC, **CPMA**
Stella D Vardoulakis, CPC, **CEMC**
Stephanie M Payton, CPC, **CPMA**
Stephanie Suess, CPC, **CCC**
Susan E Concilio, **CANPC**
Susan L Mathis, CPC, CPC-H, **CPCO**, CGSC
Susan Pepin, CPC, **CEMC**
Suzanne Donnelly, **CPMA**
Suzanne L Mucha, CPC-A, CPC-H-A, **CPMA**
Takessa L Grant, CPC, **CPMA**
Tatyana Sushkina, CPMA, **COBGC**
Teresa Kay Dymock, CPC, **CEMC**, CPEDC
Terie Lynn Charrette, CPC, CPC-H, **CPMA**, CEMC
Thomas Leppert, CPC, **CIRCC**
Tina Marie Palmer, CPC, **CPMA**
Tonie Hines, CPC-A, **COSC**
Traci H Edwards, CPC, **CPMA**, CEMC
Valerie Harvey, **CRHC**
Vivianne Marcel-Perez, CPC, **CPMA**
Walter Smith, CPC, **CPCO**
Zoila Hanson, CPC, **CFPC**

Magna Cum Laude

Amy Mulvihill, **CPC-A**
Amy Swayze, **CPC-H-A**
Angela Collins, **CPC**
Ann Eichman, **CPC**
Brenda Wieber, **CPC-A**
Carolyn Neumann, **CPC**
Chris Frazier, **CIRCC**
Christine Jenkins, **CPC-A**
Cynthia Marie McDonnell, **CPC-A**
Della Matsumura, **CPC-A**
Diana Oroz, **CPC-A**
Elizabeth Gort, **CPC-A**
Evan Gwilliam, **CPC**
Heather Erhart, **CPC**
Heather Erhart, **CPC**
Janet Shelton, **CPC-A**
Julie Elms, **CPC-A**
Karen Bryan, **CPC**
Kassandra Alvarez, **CPC-A**
Kathleen Gardzinski, **CPC**
Kathy Bone, **CPC-A**
Kay Barker Callis, **CPC-A**
Kimberly J Fields, **CPC-A**
Kristi Kirby, **CPC-A**
Kristi Lea Persinger, **CPC**
Leva Marvin, **CPC-A**
Magdalena Cesar-Aime, **CPC-A**
Maria Alaine Stroul, **CPC-A**
Monica E Paraboo, **CPC**
Sarah Clark, **CPC-A**
Stefanie Jo Lawrence, **CPC**
Theresa Benoit, **CPC-A**
Teresa Colbert, **CPC-A**
Yoanny Figueredo, **CPC**

Hot Topic: Colorado (continued from page 41)

they face is that, according to Healy, "some of the people on the job have not been trained on why we bill, the way we bill … there will be people who do not know how to play by the rules, but certified coders are trained to do this."

Although the recommendation of using only certified coders came up in the discussion, Healy said it "doesn't necessarily mean that we can make it part of the law, but it certainly has been brought up by both sides that certified coders know the information and would be more effective in using it."

We all have thought, "wouldn't it be great if we could all just use the same guidelines for coders." Healy said the way things are now, "You have to know which insurance you are billing and if the patient changes insurance, you have to go back and redo the whole system on how you entered the code. It is such a disaster when it comes to those types of things." Healy added, "And then if they change the rules on you and you have to go back in again and start all over from the beginning." Standardizing all payer claims, she concluded, "is something that really should be helpful for coders, especially those who do surgical types of procedures."

Will Other States Take the Initiative?

Healy is on the Task Force's Sustainability Committee, trying to figure out how the industry can get the information it needs without additional cost to the system. "This type of effort would be very helpful to other coders in other states, as well," Healy said. "Colorado is a great place to start since we have the processes already in place, but this is really a united effort that would help everyone in health care."

Nationally people are watching what is going on with this initiative. The task force is in contact with Washington about the progress of this effort.

As far as AAPC's stand on standardizing claim edits, on Nov. 17 and 18, the National Committee for Vital Health Statistics held hearings on the need for uniform standards and edits across the industry. AAPC's **Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, COBGC, CPEDC, CENTC**, vice president of ICD-10 education, offered testimony on the daily frustrations currently encountered by AAPC members. If you'd like to read her testimony about the need for a unified edit standard, go to AAPC News at: http://news.aapc.com/index.php/2011/12/aapc-requests-uniform-standards-and-edits-at-hearing/#more-16992.

Michelle A. Dick is executive editor at AAPC.

For more information, go to:

House Bill 10-1332 "Medical Clean Claims Transparency and Uniformity Act" (http://hb101332taskforce.org/index.php/public-documents-for-medical-claim-edits)

AMA's "Standardization of a code-editing system white paper," page 5 (www.ama-assn.org/resources/doc/psa/standardization-code-editing-whitepaper.pdf)

HCPF Hot Topics Legislative Report, Sept. 30, 2010 (www.colorado.gov/cs/Satellite/HCPF/HCPF/1221475084921)

ACT 61 of 2009, Section 30, "Edit Standards Workgroup Report," Jan. 1, 2011 (www.leg.state.vt.us/reports/2011ExternalReports/263453.pdf)

Vegas 2012

AAPC 2012 NATIONAL CONFERENCE

LAS VEGAS, NV

APRIL 1 - 4

SAVE $100!

REGISTER BY JANUARY 20!

EARLY BIRD PRICE: $695 FOR MEMBERS

April 1 - 4 | Up to 18 CEUs | 70+ Sessions

www.aapc.com/lasvegas

AAPC
Credentialing the Business Side of Medicine

Holly M. Haller, CPC, CCS, RHIT

Compliance Program Specialist, VA Boston Healthcare System

Tell us a little about yourself

I came into the coding world rather late and certainly through the back door. My entire life has been spent in the total immersion of my passion with competition horses. I rode all day, every day, for years. I managed a boarding farm, served on organizing committees for advanced level horse trials, and was exposed to the international world of equestrian competition.

Ultimately, the day came when I had to settle down and find a job. I had no direction, other than an inherited interest in science (with an internal medicine physician and a physical science and astronomy teacher for brothers). I'm strong in anatomy and disease process, and I'm persnickety by nature—perfect for coding!

Fortunately, Boston has a big medical community with coding education readily available. After earning my credentials, I started coding immediately with the Veterans Administration (VA) Boston Healthcare System. After 11 years of coding, I moved into hospital compliance, working directly with the facility compliance officer who is a positive mentor and innovator. I learn something new everyday about the role compliance plays in hospital management. I am thankful for those years of inpatient, outpatient, and surgical coding. They have served me well because now my days are filled with physician education, coding audits, and studies for improving coding and billing processes.

What is your involvement with your local AAPC chapter?

I participate in the local Rhode Island and Massachusetts AAPC chapters and I take advantage of their meetings and lectures. New England has strong, active chapters offering introductory level and refresher training. We all know that continuing education after being credentialed is a necessity. If you want to be a contributor to your facility, the education must continue. I encourage all coders at the VA who are not credentialed to bone up and take the test. You gain so much personally and professionally. Best of all, *Coding Edge* comes to your door each month!

What has been your biggest challenge as a coder?

My first challenge is finding the time to keep up with necessary literature regarding all the health care regulation and code changes. Coding is anything but static and I love having a personal reference library to tap into quickly when I need information. My second challenge is structuring a persuasive, concise, and customized explanation of coding guidelines for different physician services at the hospital. Our physicians want to know specifically how their work translates into medical center revenue and workload for their service. They want the short version. It takes a lot of behind-the-scenes work to develop short and accurate information they want as a "take-away."

What AAPC benefits do you like the most?

Coding Edge is the hands down winner! I always make time to read it cover to cover, and then I pass it on to any of our coders who want a great lunchtime read. It is just the right amount of information, delivered in an unambiguous writing style. Next on my list is AAPC's seminar program. The location schedule is accommodating, the cost is reasonable, and the presenters demonstrate good knowledge.

How is your organization preparing for ICD-10?

The VA is quite proactive with this looming challenge. It estimates about 175,000 employees will require training before ICD-10 is implemented on Oct. 1, 2013. This will range from brief online awareness sessions, to multi-day, hands-on learning courses. Facilities will designate "super users" who will understand software functionality, assist staff with correct code determination, and provide hands-on end user training as a supplement to the national training efforts. There are three or four ICD-10 self-learning modules available nationally through the VA's "Educode" online education program, developed by MC Strategies. These will be expanded to 26 modules in 2012. By the summer of 2013, there will be a three-day, face-to-face training session in each of the VA's 21 Veterans Integrated Service Network (VISN) regions. Clinical staff will also receive educational materials outlining the documentation changes associated with ICD-10 conversion.

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

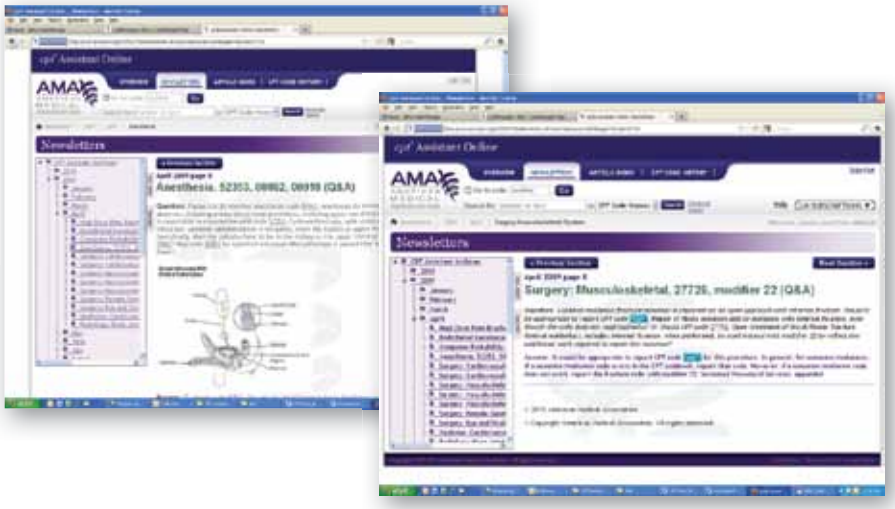
I love problem solving, specifically developing training tools for users. I enjoy taking a problem apart and having a good look. I think any job where I can dissect an issue, then research existing guidelines that influence choices, create learning scenarios with right and wrong responses, and creatively display the correct process for making decisions would be satisfying for me.

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

I am very involved in old house restoration (not renovation). My house is 95 years young compared to real antiques here in Massachusetts. It was in terrible shape when I bought it, so I launched a full scale restoration project. I worked with an architect and researched the features that were appropriate for the house's age. I gutted it and restored it. Now that it's over, I am ready to do it again—this time, with a *really* old house. I like the challenge.

CPT® Assistant is now available online!

online AMA cpt Assistant



Monthly updates included

The *CPT® Assistant* newsletter is the authoritative voice of CPT® and the most trusted resource for coding guidelines from the source of CPT—the American Medical Association (AMA).

Now available as a web-based product, *CPT® Assistant Online* offers the content medical coding professionals rely on daily, in an even-friendlier format.

Online features include:

- Monthly, timely CPT coding guidance
- A historical CPT code list that references when a code was added, deleted and/or revised since 1990
- Simple searchability, including intuitive menus and a cumulative index of article titles
- Coding references and clinical examples you can use everyday
- Anatomical illustrations, charts and graphs for quick reference
- Continuing education units, and more!

Visit the all-new AMA Coding Online site at *amacodingonline.com* today to learn more about *CPT Assistant Online* and the other best-selling, web-based products available.

Enter promotion code AEOLCPTW to save 15% on a one-year subscription or 25% on a two-year subscription. Email *bookandonlinesales@ama-assn.org* for pricing information for 11 or more users.

AMA AMERICAN MEDICAL ASSOCIATION

Visit the new AMA Coding Online site today at *amacodingonline.com* or call (800) 621-8335 to learn more.

Join NAMAS in Las Vegas at the RIO Casino Resort March 30-31, 2012

Place your Bets....and Ante up your Career

CPMA® Educational Training

- 2-day Live training for CPMA® Examination Prep
- Breakfast and lunch during the two day event
- 16 CPMA®/CPC® CEUs
- Convenience of same session testing available on April 1, 2012
- **Special Conference Pricing—$695**

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