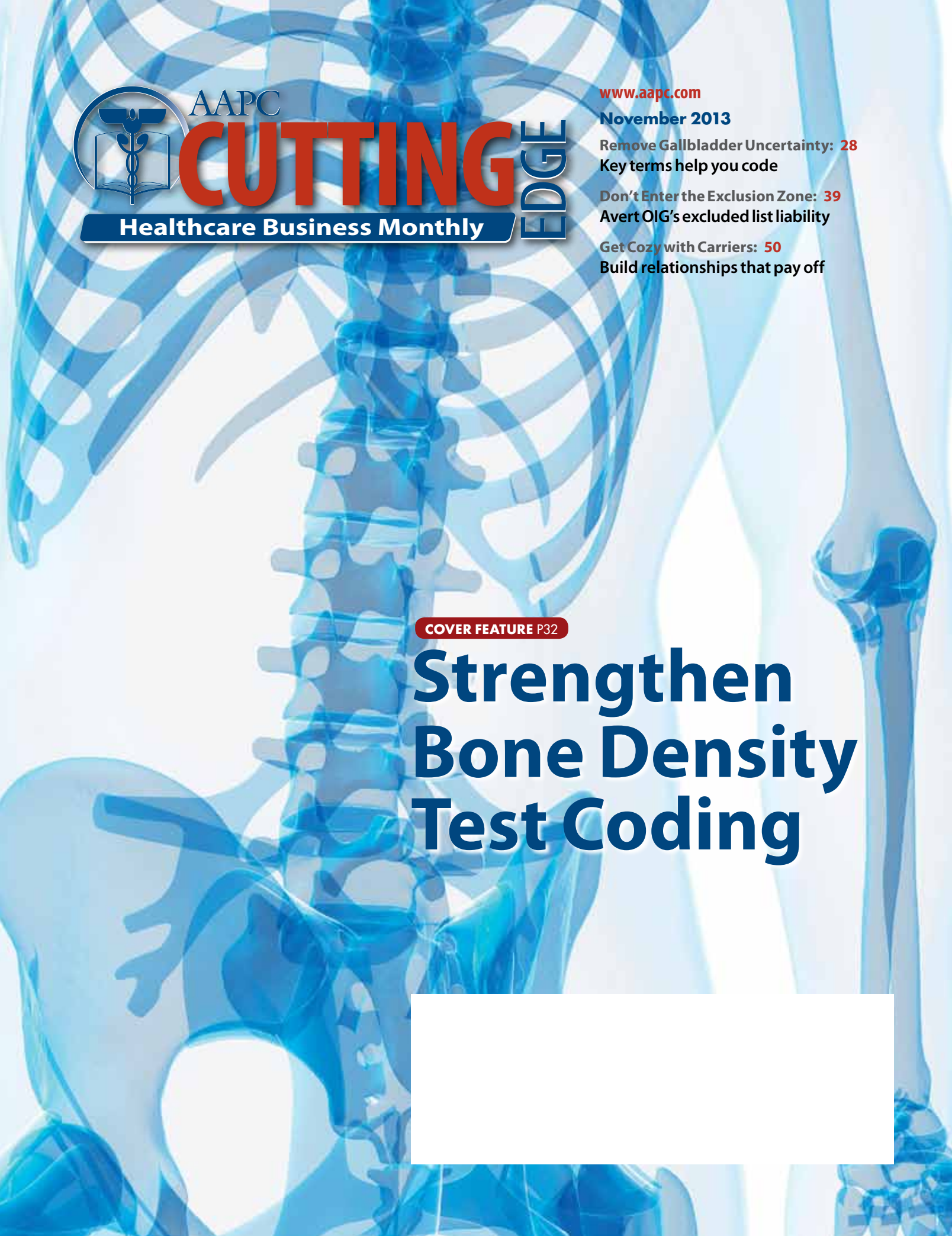
AAPC
CUTTING EDGE
Healthcare Business Monthly

www.aapc.com
November 2013



COVER FEATURE P32

Strengthen Bone Density Test Coding

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■ Coding/Billing

Strengthen Your Bone Density Test Coding

Ken Camilleis, CPC, CPC-I, CMRS, CCS-P

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DEPARTMENTS

EDUCATION

COMING UP

- **CPT® 2014**
- **Special Investigation Units**
- **OB Coding Myths**
- **WWII Health**
- **Consent Forms**

On the Cover: *Ken Camilleis, CPC, CPC-I, CMRS, CCS-P, discusses how to to strengthen your coding for bone density test claims. Cover photo by istockphoto©Eraxion. Cover design by Tina Smith.*

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AAPC CUTTING EDGE
Healthcare Business Monthly
November 2013

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Volume 24 Number 11 November 1, 2013
AAPC Cutting Edge (ISSN: 2326-2575) is published monthly by AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208, for its paid members. Periodicals Postage Paid at Salt Lake City UT and at additional mailing office. POSTMASTER: Send address changes to: Cutting Edge c/o AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208.

Achieving Our Full Potential Together

Jason VandenAkker joined AAPC as CEO in September. Prior to AAPC, he served in leadership roles at UnitedHealth Group®. Most recently, he was chief operating officer and general manager of Optum's Complex Medical Conditions business. He also held other executive leadership roles in the Consumer Business, Strategy & Business Development, Decision Support, and Wellness units.

Before UnitedHealth Group®, he worked in professional services as an associate at both MedEquity Capital and The Parthenon Group. He began his career at Oculus Technologies.

VandenAkker has a B.S. in Economics and a B.A. in Political Science from the University of Utah and an MBA from Harvard Business School. He lives with his wife and four children in Salt Lake City, Utah, where they enjoy participating together in snow skiing and water skiing, youth sports, and cycling.

Dear AAPC Members,

Thank you for your commitment to professionalism and the positive impact you have on the healthcare system. I am grateful to be part of such an outstanding group of people, and I am honored to work together with you to advance the business of medicine.

Our healthcare system is experiencing some of the most dramatic convulsions most of us can remember. Upcoming implementation of ICD-10, electronic health records, and many facets of the Affordable Care Act mean our industry—and our roles—will never be the same.

These changes are exciting for a couple of reasons. First, our healthcare system can be better for everyone—the patient, the provider, and the payer—and change is required to reach an improved state. Second, change always presents those who are well prepared with great opportunity.

At AAPC, we focus on helping you not only to prepare for the changes but also to take full advantage of them. For example, we provide ICD-10 coding, documentation, and implementation training for AAPC members and providers locally, regionally, and nationally. We develop and deliver new information and tools like AAPC Coder to assist with coding, billing, auditing, and practice management. We continue to offer networking and coaching opportunities through which you can share knowledge and experience with your colleagues throughout the AAPC family.

The latter area—spending time together at conferences, and local chapter meetings—is among the most critical. The way for each of us to improve, and to improve the healthcare system, is to work together. Together we can achieve our full potential.

I am thankful for the privilege I have had to meet with some of you at regional conferences and local chapter meetings. And I look forward with great excitement to connecting with many more of you as I continue to attend conferences and visit local chapters. I am anxious to learn from you and to better serve you.

Thanks again!

Jason VandenAkker, CEO, AAPC

Modifier 24 Is Useful When Treating Underlying Problem

"Related or Not? Pass the Modifier 24 Paternity Test" (August 2013, pages 24-25) did not fully explain the use of modifier 24 *Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period* for the treatment of the underlying problem.

Medicare has defined postoperative care as related to recovery from the surgery, but treatment of the underlying problem is considered separately billable. Medicare considers pain control and wound care as postoperative care, along with any complication that doesn't require a return to the operating room. The information below is provided on the Medicare administrative contractor (MAC) WPS® Medicare website (http://wpsmedicare.com/j8macpartb/resources/modifiers/modifier-24.shtml) to explain appropriate use of modifier 24.

- Append modifier 24 to the evaluation and management (E/M) procedure code.
- Use on an unrelated E/M service beginning the day after a procedure, when the E/M is performed by the same physician* during the 10 or 90 day postoperative period.
- Use modifier 24 on the E/M if documentation indicates the service was exclusively for treatment of the underlying condition and not for postoperative care.
- Use modifier 24 on the E/M code when the same physician* is managing immunosuppressant therapy during the postoperative period of a transplant.
- Use modifier 24 on the E/M code when the same physician* is managing chemotherapy during the postoperative period of a procedure.
- When the same physician* provides unrelated critical care during the postoperative period

***Same physician – Medicare regulation states:** "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."

CPT® defines post-operative care as "routine follow up," and considers complications to be outside that definition. As such, the information above pertains only to payers that follow the Medicare complication rule.

LuAnn Jenkins, CPC, CPMA, CEMC, CFPC

Speak Up and Be Heard!

Do you have a question regarding information found in *AAPC Cutting Edge*? Or maybe you have a difference in opinion you would like to share with your peers? Write us at: letterstotheeditor@aapc.com.

Be More Specific, Please

I enjoyed "Report Audit Results to Educate" (September 2013, pages 57-61), as I seldom see hierarchial condition category audits referenced. Because diagnosis codes provide the foundation of medical necessity for the CPT® codes billed, however, I was disappointed that so many ICD-9-CM unspecified codes were used in the audit code (Example B), and that the author didn't initiate education on the need for greater specificity in documentation for accurate diagnosis coding.

Susan Louis, RN, MS, CPC

We absolutely agree on (and regularly stress in these pages) the importance of reporting diagnoses to the highest level of specificity, and of the necessity of physician education, especially as ICD-10-CM implementation approaches. As you note, it's important to practice what we preach. Thank you for the reminder.

AAPC Cutting Edge

Hearsay, You Say?

I look to AAPC as an authoritative source of information. It is my expectation that articles accepted for publication in *AAPC Cutting Edge* are properly researched and sourced. Therefore, I was surprised to see that "Apply Your Sinusitis Knowledge to ICD-10-CM and EHRs" (September 2013) cited Wikipedia.com as a source of anatomical information.

Wikipedia is a user-generated content website, which allows anyone, regardless of their credentials or knowledge, to contribute and edit information. The information is not peer-reviewed by experts to vet its accuracy. We have access to much online information that is vetted, including other sources cited in the article. One of these reliable sources easily could have been used for the definition of paranasal sinuses.

Lorraine Papazian-Boyce, MS, CPC

The Wikipedia.com information cited in the article was both accurate and properly cited, but the word of caution is well advised: Whether coding or billing claims, creating a compliance or education program, or preparing to appeal a payer decision (and much more), best practice is to follow official, verified guidelines and sources.

AAPC Cutting Edge

CMS Allows '97 Extended HPI with '95 Guidelines

The Centers for Medicare & Medicaid Services (CMS) has revised its *Documentation Guidelines for Evaluation and Management (E/M) Services* to allow physicians to use an extended history of present illness (HPI), as defined by the 1997 guidelines, with the other elements of the 1995 guidelines. This means that, effective Sept. 10, "the status of three or more chronic conditions" qualifies as an extended HPI for *either* the '97 *or* '95 guidelines.

CMS announced the change in a FAQ on 1995 and 1997 Documentation Guidelines for Evaluation & Management Services (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/EM-FAQ-1995-1997.pdf):

Q. Can a provider use both the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services to document their choice of evaluation and management HCPCS code?

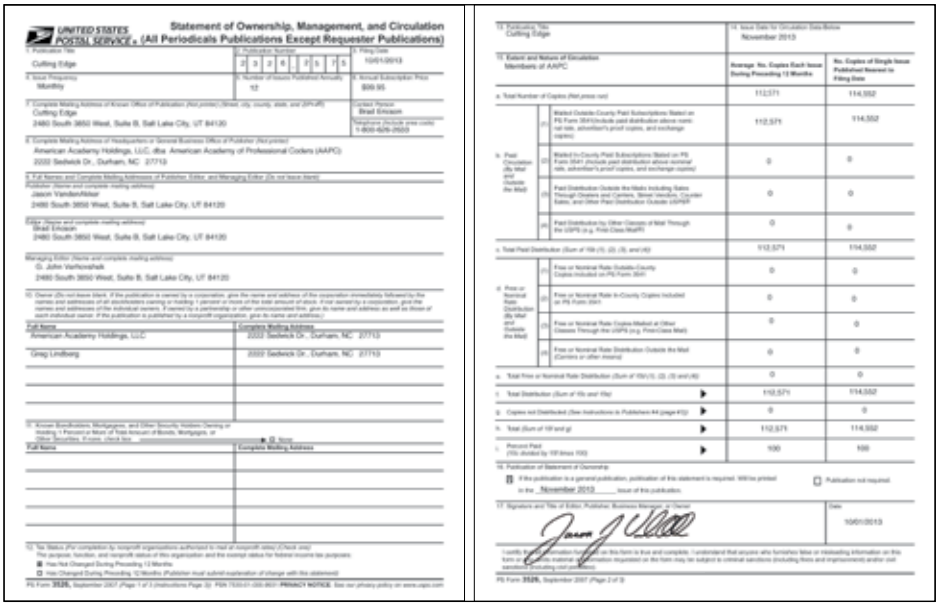
A. For billing Medicare, a provider may choose either version of the documentation guidelines, not a combination of the two, to document a patient encounter. However, beginning for services performed on or after September 10, 2013 physicians may use the 1997 documentation guidelines for an extended history of present illness along with other elements from the 1995 guidelines to document an evaluation and management service.

The change doesn't allow physicians to document less, but it does allow greater flexibility in applying the '95 guidelines.

"Now, physicians can use 1995 Exam and status of the three chronic conditions, rather than having to document four or more of the eight HPI elements, as required by the '95 guidelines," explains **Elin Baklid-Kunz, MBA, CPC, CCS**, who first heard about the change at a Medicare administrative contractor (MAC) advisory group meeting in late August.

"I personally feel, and I think many agree with me, that this will have a very positive impact for physicians who prefer to use the 1995 exam—and especially for family practice and internal medicine, as physicians in these specialties manage the patient's chronic conditions," said Baklid-Kunz.

CMS will issue a change request and update E/M guidelines to reflect this policy change.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Differentiate Swing Bed Rates in 2013 and 2014

Medicare payment rates for skilled nursing facility (SNF) swing bed services have been updated. Take note of the different rates for 2013 and 2014.

Medicare swing-bed SNF rates for services during 2013 (on or after Jan. 1, 2013) are:

Region	Routine Payment
1	234.06
2	217.31
3	201.32
4	197.90
5	175.53
6	186.91
7	171.70
8	204.98
9	222.35

Medicare swing-bed SNF rates for services during 2014 (on or after Jan. 1, 2014) are:

Region	Routine Payment
1	239.51
2	222.37
3	206.01
4	202.51
5	179.62
6	191.26
7	175.70
8	209.75
9	227.53

For more information, see *Provider Reimbursement Manual*, part 1, chapter 22, Determination of Cost of Services to Beneficiaries, section 2231, "Regional Medicare Swing-Bed-Rate," and CMS transmittal 458 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R458PR1.pdf).

More on page 54

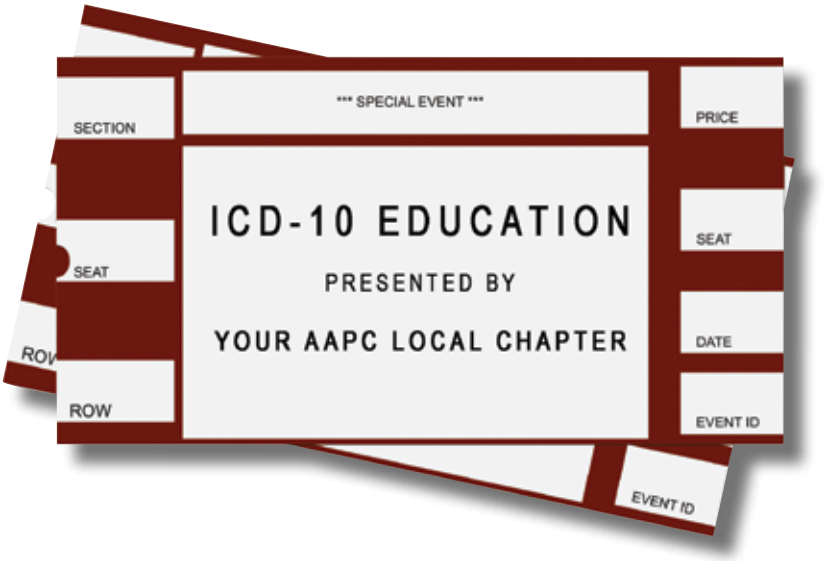
Give a Pat on the Back, Get One Back

We want to recognize our members' accomplishments. Have you had a recent promotion? Do you have a colleague who does wonderful things for the coding profession?
Send your success stories to kudos@aapc.com.

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

Put ICD-10 to Work for Your Chapter

Your chapter can be a fast-track ticket to ICD-10 education.



ICD-10 implementation is less than a year away, and AAPC local chapters are gearing up to help members prepare for this monumental change in diagnosis coding. If your chapter is slow to leave the station, here are some ways to get that engine running.

Map Out an Education Plan

With so many curriculum options offered by AAPC, you might not know where to start. To navigate through the education process more easily, use the "Coder's Roadmap to ICD-10" curriculum plan, available on the AAPC website (http://cloud.aapc.com/documents/RoadmapFlyer41213%282PgWeb%29V1.pdf). The timeline shows you the various steps you'll need to take before you can comprehensively use ICD-10-CM codes beginning Oct. 1, 2014.

Bring Anatomy and Pathophysiology (A&P) to Your Chapter

A&P is Step 2 in your training process. If your chapter hasn't started reviewing anatomy and terminology in your meetings, suggest it. You might even take the lead and find creative ways to present these topics to your chapter. This is a great way to learn along with other members.

Get Together for ICD-10 Game Night

Code set training is Step 3. If your chapter hasn't already tackled this, it's time for you to get the ball rolling. Take the initiative to start a study group with other chapter members. Games like ICD-10 "Coding Jeopardy" or "Wheel of Coding" are fun ways to learn. If you have an officer in your group, he or she has access to some of these games on the "Officer's Resource" tab on his or her AAPC membership page. I'm sure once you become an ICD-10 game expert, you'll want to share the fun at a chapter meeting.

Host an ICD-10 Workshop

An ICD-10 workshop presented by an AAPC trained expert is a benefit only offered to chapter members, and is a very cost effective way to receive excellent training. Volunteer to help organize the event, if necessary. If you reach out and network with friends in nearby chapters, they may want to join in. Together, your officers and theirs can make a successful path to learning. Two-day training can be held for 50 members starting at about $180 per person. Volunteering to help your chapter organize a workshop will also sharpen your leadership skills.

Look to Professional Coding Instructors

If you aren't comfortable with presenting, find an AAPC Certified Professional Coder-Professional Medical Coding Instructor (CPC-I®) in your chapter. Many instructors have taken AAPC's ICD-10 Code Set Training course to become expert ICD-10 trainers and would probably be happy to present at a chapter workshop or other training genre.

Jump on Board

There is a lot to learn to be prepared for ICD-10 and the clock is ticking. Every day that passes is an opportunity missed for essential ICD-10 training. There are lots of ways you can learn in your chapter. Find one that works for you and get on board the ICD-10 express.

Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC, is coding and billing manager for Travis C. Holcombe, MD. She has 20 years of coding and billing experience, is an AAPC workshop presenter and AAPC ICD-10 trainer, and served on the AAPC National Advisory Board from 2007-2009. She was the 2012 president of the West Valley Glendale chapter, and has held offices with the Phoenix chapter. She is also a member of the 2012-2013 AAPCCA board of directors, region 8-West.

By Faith C.M. McNicholas, RHIT, CPC, CPCD, PCS, CDC

Streamline Approval of Your Next Chapter Event

If your local chapter is planning to host an educational event which offers continuing education units (CEUs), you'll need to get it approved by AAPC first. AAPC provides local chapter officers with a thorough, fair review process for such events.

To ensure a timely response, AAPC recommends that all chapter event requests requiring CEU approval be made at least 30 days prior to the event. Last-minute submissions (less than two weeks before the event) risk denial of application. Early and timely submission allows for adequate processing time and guarantees your members will receive plenty of notification for the upcoming event.

To make an event submission, follow these guidelines:

Go online – At www.aapc.com/MemberArea/Chapters/events.aspx you can request CEUs for upcoming chapter events. Simply select "your event type," and follow the instructions to complete the application.

Provide detailed information about the presentation – For all meetings lasting three hours or longer, you must submit an agenda. Include detailed information about breakout sessions, breaks, lunch, etc. Failure to do so may result in denial of CEU approval. Submit the agenda as a Microsoft® Word document (.doc).

Allow analysts time to review your request – Processing time can range from two to four days, depending on request volume.

Update your submission, if necessary – If you experience an unexpected event, topic, or speaker change, do one of the following:

- Edit the event online;
- Email AAPC at localchaptersceus@aapc.com;
- Call the CEU Vendor Department to inform them of the change and the circumstances surrounding the change; or
- If the change occurs after business hours, contact AAPC's CEU Vendor Department at 1-800-626-2633, ext. 115, and leave a message. Someone will contact you.

To check your event request status, visit your "My Local Chapter" page (www.aapc.com/memberarea/chapters/index.aspx). Look under "Local Chapter Events" to see if your event is listed. If not, the request may not have gone through or is still in the review process. Before resubmitting a request, please verify with AAPC for confirmation.

For more information on submitting event requests and CEU approval, review Appendix A in your *Local Chapter Handbook*.

By Hardship Scholarship Committee

In Crisis We Can Help Retain Your Credentials

You may have heard about the Hardship Scholarship fund at AAPC national conferences, local chapter meetings, and from peers. Donated funds come from members to help other hardworking, active members retain their credentials during times of hardship. If this is a viable avenue for you, please apply. The fund was set up by members to help members.

Learn More and Apply

To see the rules for the Hardship Scholarship fund and to answer frequently asked questions, go to www.aapc.com/MemberArea/Chapters/scholarship.aspx. You'll find details about the fund such as eligibility, how to apply, helpful tips, and what expenses might be considered.

When applying for the Hardship Scholarship fund:

- **Be thorough:** Read the application thoroughly and complete it to the best of your abilities.
- **Be professional:** Punctuation and good grammar are important in our line of work and should be reflected in the application.
- **Paint the full picture:** Include as much as you can about your circumstance to give the committee a true sense of the struggles and challenges you face.

Your application is your time to tell the committee about yourself, your hardship, what you have done in the coding community, your chapter, your career, and your future plans.

Don't Be Afraid to Ask for Help

Admitting you need help is never easy. Asking for help is even harder. But you've worked really hard to get where you are and have studied countless hours for your credentials. When it's a harsh reality that you can't make ends meet, the Hardship Scholarship fund is meant to help.

photo by iStockphoto/© Nikosa

By Rena Hall, CPC

Make "Study Hall 101" a Priority

It's a smart and inexpensive way to prep students for a coding exam.

Offering a free study assistance program in your chapter can be a valuable asset to members. Most coders aspiring to be certified have little or no money to spend on resources to help them understand coding concepts and assist them through the testing process. By offering an inexpensive—or even free—class to students, you're helping to foster coders who will become an active part of the chapter after they've passed the exam. They'll feel the chapter truly cares and they'll share that experience with others.

Study Hall Is a Bonus

A "study hall" is not meant to replace AAPC pre-certification courses or the mock examinations, nor is it to replace mentorships. It's intent should be to help students become more relaxed in their preparation for test taking.

photo by iStockphoto/© elfena

Through experimentation and getting feedback from the students involved in my chapter's study hall, we came up with tips that can be used by test takers and by members in new positions as professional coders. These tips are ways to make learning fun and build test-taking speed in your study hall.

Use Games to Build Speed

Games can help students to become familiar with CPT®, ICD-9-CM/ICD-10-CM, and HCPCS Level II books. It's important for test takers to become fast at finding coding information in these books—flipping pages can cost up to 30-45 minutes of wasted time during the test. And if you're unfamiliar with the books, you can estimate 20 seconds to find a page and then an additional three to five seconds to find the code on the page. That adds up to roughly 62 minutes of time wasted. The following games will help future coders build the speed they'll need to pass the exam.

Scavenger Hunt - Students write down on a small piece of paper several codes from each section in a code book. Throw the codes in a bowl and have someone draw one out. Time how long it takes that student to find the code in the book. You can give rewards if he or she keeps it under a particular time.

Match Game - Have students match modifiers to particular service codes that allow their use.

Meat and Potatoes - Supply an actual, redacted operative report for students to review. The focus of the game is to find where the "salad" stops and the "entrée" begins. Everyone goes to the operating suite, gets prepped, and an incision is made (salad). Students need to know when the surgical part (entrée) begins in the report.

Cover Important Test Strategies in Study Hall

Students need to know when to stop looking for a particular answer. Test takers who struggle with an answer need to move on, returning to it only when finished with all of the other questions.

Students should try to answer all of the questions—a guess has a chance at being right, but an unanswered question is 100 percent wrong. They can't depend on answering a certain number of questions and all of them being correct. Even though this is noted in the Proctor Instructions, it's surprising how many count the questions they answer and hope for the best.

The focus of the game is to find where the "salad" stops and the "entrée" begins.

Review Test-taking Essentials

Another tip is to be sure your students have a good understanding of:

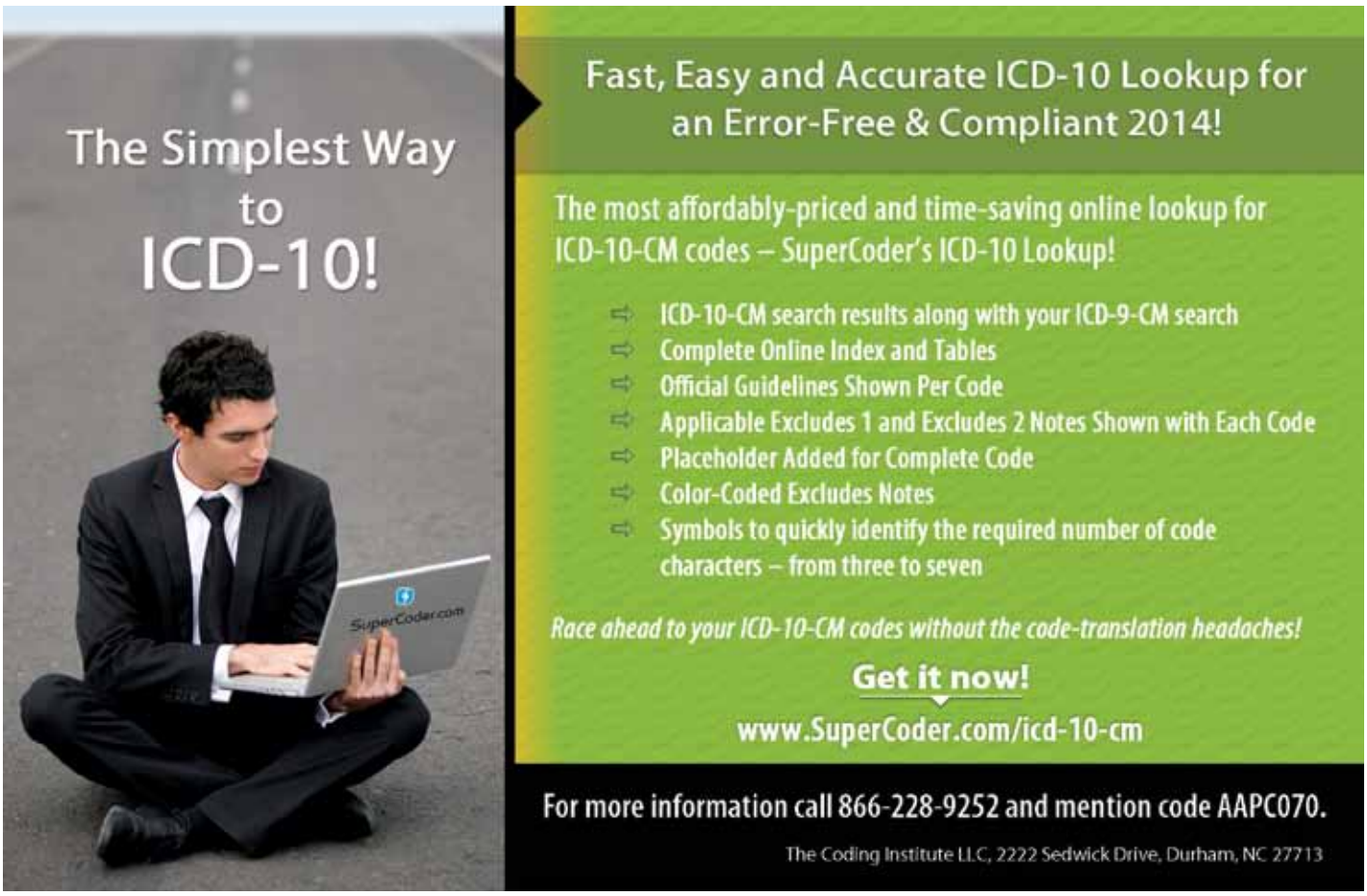
- **Guidelines:** The information that's noted in the coding guidelines is an integral part of getting an answer correct.
- **Modifiers:** The student needs to pick out easily which modifiers are evaluation and management (E/M) only. This way, they can skip over answers that include E/M modifiers placed with procedures.
- **Terminology and Anatomy:** Have students make a list of important pages (diagrams, definitions, etc.) on a blank page in the front or back of their code books for them to quickly and easily reference, when necessary.

Keep Calm and Take the Test

In study hall, let students know the test is open book and they should do their best to relax throughout the process. Stressed test takers tend to make mistakes. The calmer a person is, the better he or she will do.

Get involved in helping future coders become successful. Be there for them and the rewards will benefit the entire organization.

Rena Hall, CPC, began her career in the medical field as a medical assistant in 1982. She became a certified coder in January 2001 and has been an active member of the AAPC Kansas City, Mo., local chapter ever since. Hall has worked for the same neurosurgery group for almost 26 years.



By Erin Andersen, CPC, CHC

Ask for (and Get) Documentation Addenda

Know when it's a G.O.O.D. idea, and how to do it properly.

As a coder, you are responsible for assigning codes to services supported by documentation. You also have a responsibility to look for what *isn't* in the documentation. When evaluating a provider's encounter notes, ask yourself:

- Is there contradictory information?
- Given what I know of this procedure, does the information make sense?
- Given what I know of this provider, do I think there is missing or incorrect information?

Electronic health records (EHRs) give clinicians the opportunity to use templates, dot phrases, smart sets, and copy and paste functions to bring in large blocks of information within seconds. Although this can save time, it also can compromise the integrity of the document if the provider does not edit the record carefully.

This raises an important question: When there isn't enough information in the record to select a code, or you suspect there is missing or incorrect information, is it appropriate to seek an addendum from the provider? I have a process you can use to determine if an addendum is a **G.O.O.D.** idea.

Gather

To know if there is missing or incorrect information, you'll need to know some facts about the provider's process. Meet with the provider and ask him or her to walk you through a typical patient encounter. For instance, ask the provider to describe a typical clinic visit; or, more simply, ask, "What are the steps you usually take when you perform that surgery?"

You may ask or be invited to shadow the provider for a morning to get a feel for his or her routine. Providers are often enthusiastic to show you what they do. They realize having you understand their work may help them maximize revenue with appropriate billing. Whether you meet with or shadow a provider, note all of what you learn so you can reference it later. I keep files on all my providers.

Opportunity

Once you have met, and possibly shadowed, your provider, scrutinize the documentation again. Is the provider doing work that isn't being captured in the notes? Is the provider not doing work that is being captured in the notes? After you compile a list of questions, meet with the provider again to discuss them. Example questions may include:

- "I see that you included a comprehensive past medical, surgical, family, and social history in your subsequent hospital visit note. From our previous conversation, it sounds like you typically do not discuss this information at subsequent visits. Was this information brought in as part of your template for diary purposes?"
- "In looking at your procedure report, I do not see that you used ultrasound guidance. But when I shadowed you, I remember you often used it. Did you use it this time? If so, the primary procedure code allows you to bill separately for the guidance."
- "When we met a few weeks ago, you explained that you almost always do a record review before meeting with a new patient. I do not see that a record review summary was documented for this patient. Did you perform a record review for this patient?"

Be careful to ask questions respectfully, with the intent of seeking to clarify what is documented. Taking an accusatory tone will shut down the healthy dialogue you have going.

Be careful to ask questions respectfully, with the intent of seeking to clarify what is documented. Taking an accusatory tone will shut down the healthy dialogue you have going. Your provider will likely become defensive and all future interactions could be difficult or strained.

Option

Once you have the answers to your questions, decide if it is appropriate to addend the documentation. Your decision will depend on how long ago the date of service was from when your provider would addend. Much hinges on how clear your provider's recollection is of the encounter.

In general, insurance companies frown on addenda completed weeks or months after the date of service because the validity of the information could be called into question. If the provider has very clear recall of that specific encounter, however, and the intent is to correct inaccurate information, an addendum for the note is recommended.

Document

If you identify missing or inaccurate information, and determine that it's appropriate for the provider to addend, ask your provider if he or she is willing to addend to make the record correct. If you have an EHR, the system will automatically stamp the date, time, and author of the addendum.

It's important to addend the specific encounter in question because the two notes will not be linked, nullifying the intention to correct the original note. For handwritten notes, the addendum should be placed as close to the original note as possible so the information can be found easily. The provider should:

- Date the note he or she is addending;
- State the original date of service;
- Document the new information; and
- Sign the addendum.

If appropriate, the provider may line through (once!) incorrect information in the new note, with his or her initials and the date next to the line-through. The addendum should contain the factual information that was omitted or inaccurately reported in the original note. If the new information contradicts the old information, a brief statement of explanation may be warranted.

Example 1: One of my provider's forgot to include record review information is his new patient clinic note. I suggested that he add a statement like so: "I performed a record review prior to my visit with the patient. Pertinent details include …" This information could now be used to select the appropriate level evaluation and management (E/M) code.

Example 2: A provider stated in his review of systems that the patient had not lost any weight, but in looking at the patient's questionnaire, the patient reported recently losing 10 lbs. When transferring the data from the questionnaire to the EHR, he accidentally left the default answer under Constitutional as "no weight loss." Because of the potential for continued errors and the inefficiency of his process, I suggested that he review the questionnaire, reference it, and have it scanned into the EHR. I asked him to addend his note to correct the information: "Correction: I erroneously reported that the patient has not lost any weight. She, in fact, has lost 10 lbs. Please see the scanned questionnaire."

Time Invested Pays Off

Don't be concerned about how to balance the addenda process with maintaining your productivity quotas. Any effort you put into gathering information about your provider's process, and educating him or her about documentation rules, will save you time (and your provider money) down the road. Your provider will see that you are invested in helping the practice maximize reimbursement by improving documentation, and he or she will respond in a timely fashion out of respect for what you do. Over time, you will have to request fewer addenda, and your provider's documentation will be much easier to code. And that, my fellow coders, is priceless!

Erin Andersen, CPC, CHC, is a compliance specialist at Oregon Health and Science University in Portland, Ore. She has over 10 years of coding experience. Andersen serves as president for the Rose City Chapter and is the Region 8 representative for the AAPCCA board of directors.

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By David Dunn, MD, FACS, CIRCC, CPC-H, CCVTC, CCC, CCS, RCC

Instill Ideal Reporting Practices for IR and Cardiology

Recognize strengths and weaknesses in procedure documentation to ensure your coding is built upon a solid foundation.

The physician procedure report is the foundation for coding, charge capture, and the reimbursement process. If that foundation is weak, your ability to code will be, too. Weak coding leads to shaky claims reporting and dangerously unstable reimbursement. Before your walls come tumbling down, consider the following recommendations to strengthen physician reporting of interventional radiology (IR) and cardiology services, and build a solid foundation for accurate coding and reimbursement.

Be Mindful of Templates

Many providers use templates to ensure the consistency and comprehensiveness of the reporting process. Templates are valuable as a reminder list, but may leave important information out and/or crowd the record with irrelevant details. Templates might also require editing (i.e., the deletion of items that have not been performed); overlooking such manual overrides may result in conflicting (and often confusing) reporting, which results in non-compliant documentation and improper coding and reimbursement.

The following is a general outline and explanation (not a template) of items that should be addressed in a typical report.

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Templates are valuable as a reminder list, but may leave important information out and/or crowd the record with irrelevant details.

Recommendations for procedural reports in IR:

- State the history, medical necessity, prior interventions, and reasons for repeat diagnostic study after prior catheter-based angiography/computed tomographic angiography (CTA)/ magnetic resonance angiography (MRA).
- State the vascular access site(s) and what is being performed (diagnostic angiography and/or intervention) via each access site, as well as timing of each procedure.
- State the vessel(s) catheterized, describing the catheter tip location and any variant anatomy.
- State the vessel(s) injected, the areas imaged (for medical necessity), interpretation of findings, specific percentage of stenosis, exact anatomical location of the lesions, and description of any normal vessels in between the stenosis, as well as if the stenosis is a lesion that bridges two vessels.
- State the intervention(s) and adjunctive procedure(s) performed. Also state any complications or additional treatments provided.
- State the specific device(s) and special supplies used during the procedure.

Recommendations for procedural reports in cardiology:

- State the history (acute myocardial infarction (MI), unstable angina, chronic total occlusion (CTO), planned intervention), prior surgeries or interventions, medical necessity for diagnostic and interventional procedures, and reasons for repeat diagnostic study after prior catheter-based angiography.
- State the vascular access site(s), and what is performed via each access.
- State the peripheral vessel(s) catheterized, describing the catheter tip location and any variant anatomy or surgically-created grafts.
- State the heart chamber(s) entered with pressures obtained, as well as any injection and images.
- State the coronary vessel(s) injected, the areas imaged (for medical necessity) with interpretation of findings, and specific documentation of exact locations of the lesions treated (native vs. graft) and the degree of stenosis of the lesions treated.
- State other diagnostic(s) performed (intravascular ultrasound, fractional flow reserve, optical coherence tomography, near-infrared (NIR), InfraReDx), as well as intervention(s) performed (angioplasty, atherectomy, bare metal stent placement, drug-eluting stent placement, and aspiration or mechanical thrombectomy).
- State the specific device(s) and specialty supplies used during the procedure.

Documented patient history is critical in defining medical necessity. For example, if a patient has hypertension and the plan is for a renal angiogram, and during the course of the procedure a celiac artery is inadvertently selected and imaged, you should not code for a visceral angiogram. The visceral angiogram was not intended, and medical necessity for it does not exist.

Watch Out for Repeat Studies

A problem involving medical necessity is that repeat diagnostic studies are not allowed; the physician must document the prior diagnostic studies, dates of service, and findings to avoid compliance issues.

It's common for a diagnostic study to be performed one day and the intervention to be performed another day, or to stage multiple interventions over the course of several days. Imaging will still be performed in these scenarios, but is not reported because it isn't considered diagnostic.

After a diagnostic CTA, MRA, or contrast angiogram is performed and a plan to intervene has been made, a repeat diagnostic study cannot be coded unless there is clear documentation outlining the reasons why (i.e., new medical necessity).

For example: A diagnostic coronary angiogram is performed, and the patient returns with new onset of angina a week later. The assumption would be that something has changed in the interim, and this change represents new medical necessity.

On the other hand, if a diagnostic MRA shows an 80 percent right renal artery stenosis, and the patient is counseled for a right renal artery stent placement, a repeat diagnostic angiogram would not be submitted during the stent placement. Any imaging is considered confirmatory or guiding.

Another example would be "re-look" angiography during planned, staged coronary stent placements. If there was no clinical change in a patient's status, you would not code for a re-look angiogram of a recent stent placement during the staged procedure; re-look, repeat, confirmatory, guiding, sizing, positioning, road mapping, and com-

Only first-time diagnostic studies should be reported, unless there is new medical necessity documented (e.g., a clinical change in the patient).

pletion angiography are not separately reported. Only first-time diagnostic studies should be reported, unless there is new medical necessity documented (e.g., a clinical change in the patient).

Note the Importance of Catheter Placement to Code Selection

Each vascular access must be reported because catheter selection is based on access site(s) and the vessel(s) selected. Documentation should specify where the catheter tip is placed for each diagnostic angiogram or intervention. It should be clear if the vessel was imaged selectively (i.e., catheter is actually within the imaged vessel) or non-selectively (catheter remains outside of the imaged vessel).

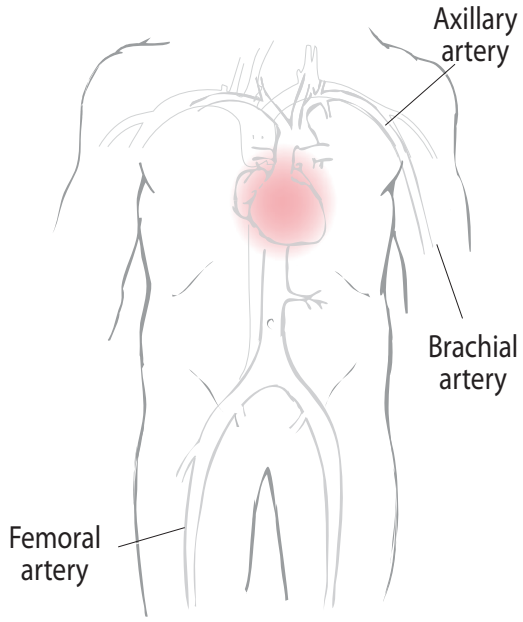
"Selective" codes may be reported only when the physician clearly documents the location of the catheter tip. For example, if bilateral renal imaging is performed from the aorta (non-selective), the codes are 36200 *Introduction of catheter, aorta* and 75625 *Aortography, abdominal, by serialography, radiological supervision and interpretation*. If each renal is selectively imaged, the code is 36252 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral.*

These codes can only be determined from the physician documentation in the report. Findings for each area imaged for medical necessity must be documented before submitting the angiographic codes. In many instances, a physician will state, "aortogram and run-off are performed," but findings are only of the extremities; aortography codes would not be submitted in this scenario.

Where stenoses are found, it's important to quantify via degree of stenosis, and/or that the stenoses are flow-limiting, to accurately define the medical necessity for possible interventions to come. Ask yourself: Is the stenosis bridging lesions involving contiguous vessels, or are they non-contiguous stenoses in different vessels? The answer will help you determine if one or two interventions may be reported.

Keep Everything in Order

All interventions should be documented in a temporal fashion. For example, if angioplasty alone is performed, but stenting is ultimately required, the physician must document the balloon size and why the result is suboptimal. By establishing the medical necessity for subsequent stenting, you may report both interventions—at least, in certain cases (this changes in 2014). For example, a 3 mm "pre-dilation" of a stenosis is performed of a subclavian to allow easier placement of a 7 mm stent. The undersized balloon pre-dilation would not be reported in this case.



Code 36200 reports introduction of a catheter into the aorta via standard access points such as the femoral, brachial or axillary arteries

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Many of the newer interventional codes bundle catheter selection (femoral stent, 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed*) or imaging (carotid stent, 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection*). Be aware of these bundling issues. Complications should be documented, as this may allow you to report further imaging and intervention codes.

Lastly, specific devices used should be documented in the report. They may indirectly affect reimbursement because there are many device-to-procedural code edits.

As in IR, degree/severity of stenosis must be documented to establish medical necessity for the interventions.

Be Precise on Vessels Selected

For cardiac reports, medical necessity and prior studies must be reported for the same reasons discussed above.

With coronary catheterization codes, it becomes important to document the vessels selected, as well as if bypasses are in place and imaged. The physician should document each chamber entered, as well as the findings, if the chamber was imaged. Pressures must be recorded to document left or right heart catheterizations.

Coronary artery intervention codes require all performed interventions to be documented (e.g., angioplasty, atherectomy, and stent placement). This information drives correct coding, as do the answers to the following questions (which should be answered within the report):

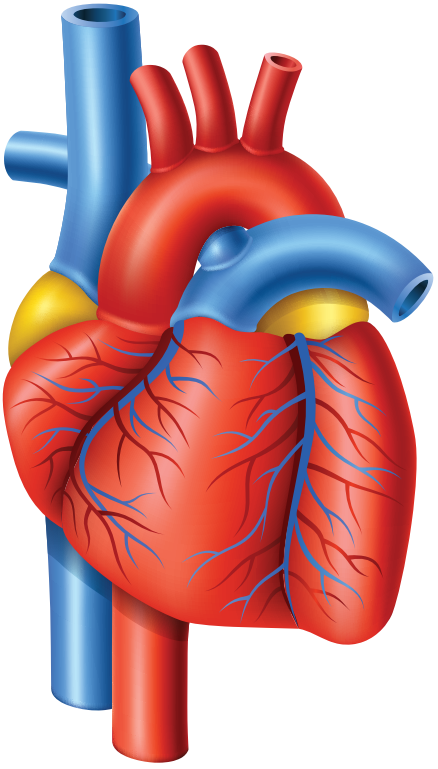
- Is there a CTO intervened upon?
- Is the intervention performed in the setting of an acute MI?
- Is this a planned intervention based on prior imaging?
- Was a bare metal stent or a drug eluting stent placed (C codes for facility Medicare reporting)?
- Is the percutaneous coronary intervention performed via or within a graft?
- Were additional branches intervened upon? With cardiac interventional codes, up to two branch interventions may be reported when performed in the left descending (LD), left circumflex (LC), and right coronary (RC).
- Was this a bifurcation lesion or a bridging lesion (e.g., if one stent is used to treat a single bridging lesion, only one stent code is reported).

Know the Major Vessels

There are five major coronary arteries for interventional coding purposes:

1. Left main (LM)
2. Left descending (LD)
3. Left circumflex (LC)
4. Right coronary (RC)
5. Ramus intermedius (RI)

Once again, specific documentation of where interventions are performed is imperative to allow for correct reimbursement. For coronary thrombectomy, whether it was mechanical (only Angiojet currently is considered a mechanical thrombectomy) or aspiration-type



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catheter (which is not reported during coronary interventions) must be determined. As in IR, degree/severity of stenosis must be documented to establish medical necessity for the interventions.

This information represents the minimum guidelines that should be addressed in the physician report for IR and cardiology services to allow for appropriate and compliant coding. When these key components are missing, and the correct code cannot be determined, an addendum is in order. These same documentation issues (and many more), will become even more crucial when the more robust ICD-10 codes are implemented Oct. 1, 2014.

As we move into the future, the need for concise, comprehensive documentation becomes even more critical to reimbursement and compliance. There has never been a better time than now to address physician reporting.

David Dunn, MD, FACS, CIRCC, CPC-H, CCC, CCVTC, CCS, RCC, is vice president of ZHealth. He oversees physician coding and instructs ZHealth educational programs, and contributes to Dr. Z's Medical Coding Series. A graduate of Texas A&M University, he completed his M.D. at the University of Texas, his surgical residency at Scott & White Hospital, and his vascular surgery fellowship at Baylor College of Medicine. A diplomat of the American Board of Surgery, Dunn is also certified in vascular surgery. He is a fellow of the American College of Surgeons and a member of the Southern Association for Vascular Surgery. He is president of the AAPC National Advisory Board and a member of the Nashville, Tenn., local chapter of AAPC.

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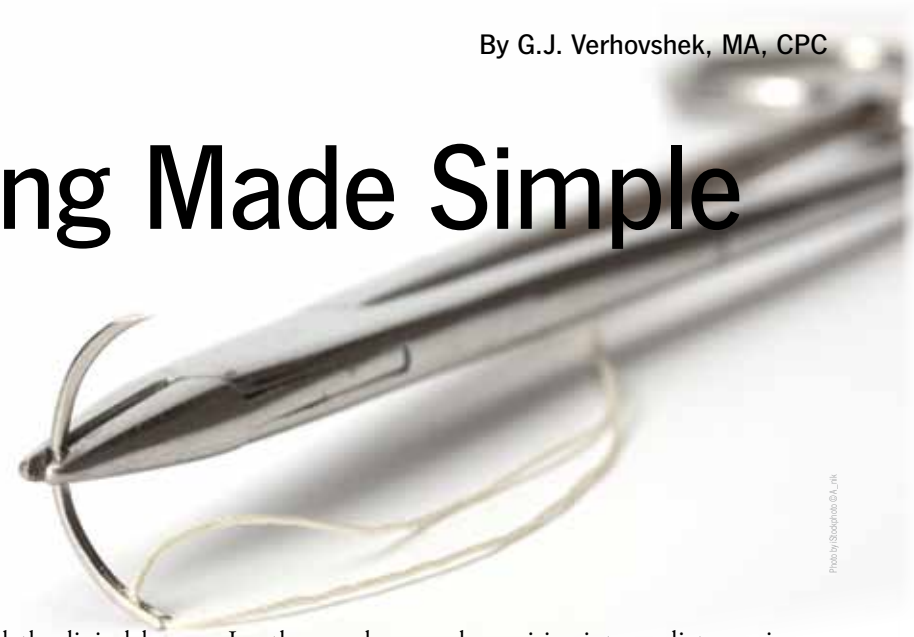
By G.J. Verhovshek, MA, CPC

Closure Coding Made Simple

Find three important details in the report, and you've got the case all sewn up.



When coding for wound repair (closure), you must search the clinical documentation to determine three things:

1. The complexity of the repair (simple, intermediate, or complex)
2. The anatomic location of the wound(s) closed
3. The length, in centimeters, of the wound(s) closed

Each of these variables is specified in the repair CPT® code descriptors. For example:

12013 Simple repair of superficial wounds [complexity] of face, ears, eyelids, nose, lips and/or mucous membranes [location]; 2.6 cm to 5.0 cm [length]

12035 Repair, intermediate [complexity], wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet) [location]; 12.6 cm to 20.0 cm [length]

13150 Repair, complex [complexity], eyelids, nose, ears and/or lips [location]; 1.0 cm or less [length]

Complexity Comes First

First, determine the complexity of the performed repair(s). Your CPT® codebook is the definitive source, providing full definitions for each type of repair:

> "**Simple repair** is used when the wound is superficial; eg, involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure."

Simple repairs are—as the name indicates—fairly straightforward, and require only single-layer closure of the affected area. Such repairs involve only the skin; deeper layers of tissue are unaffected. By contrast:

> "**Intermediate repair** … require[s] one layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia in addition to the skin (epidermal and dermal) closure."

In other words, wounds requiring intermediate repairs are deeper than those requiring simple repair. Per CPT®, some single-layer closures may qualify as complex repairs, if the wound is "heavily contaminated" and requires "extensive cleaning or removal of particulate matter."

When searching documentation for clues as to the complexity of repair, statements such as "layered closure," "involving subcutaneous tissue," and/or "removal of debris," "extensive cleansing," etc., point to an intermediate repair. Lack of these details, or a statement of "single layer closure," suggests a simple repair.

Complex repairs involve wounds that are deeper and more dramatic, which may require debridement or significant revision:

> "**Complex repair** … require[s] more than layered closure, viz., scar revision, debridement (eg, traumatic lacerations or avulsions), extensive undermining, stents, or retention sutures. Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions."

An operative note detailing such an extensive, reconstructive repair should be easily distinguished from other repair types, due to the need for procedures well beyond cleansing and suturing at one or more levels.

Second, Choose a Location Subcategory

After you've determined if the repair is simple (12001-12018), intermediate (12031-12057), or complex (13100-+13153), narrow your code selection by the documented location of the wound(s) repaired. This is best done by referring to the CPT® code descriptors. For instance, intermediate repairs are grouped into anatomic categories:

12031-12037: scalp, axillae, trunk, and/or extremities (excluding hands and feet)

12041-12047: neck, hands, feet, and/or external genitalia

Do not combine wounds of different severity or those that fall within separate anatomic locations (as defined by the relevant code descriptors).

12051-12057: face, ears, eyelids, nose, lips, and/or mucous membranes

Third, Size Seals the Deal

Per CPT®, "The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate [star shaped]." With this final piece of information, you can choose a repair code.

Example 1: For an intermediate repair (12031-12057) of a leg wound (12031-12037, extremities) measuring 10 cm, you would select 12034 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm*.

Example 2: A plastic surgeon performs a complex repair of a facial laceration, measuring 2.5 cm. Because this is a complex repair, begin with code set 13100-+13153. The complex repair codes are relatively precise regarding location, and differentiate between wounds of the eyelids, nose, ears, and/or lips and those of the forehead, cheeks, chin, mouth, and neck. If the physician documented only "facial laceration," ask for more detail. For this example, assume the wound was on the patient's left cheek. This allows you to narrow your code choice to 13131-+13133. Because the wound was 2.5 cm long, the correct choice is 13131 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm*.

Note: Complex repair codes (unlike either the simple or intermediate repair codes) employ add-on codes to describe wounds greater than 7.5 cm. Report as many units of the add-on codes as necessary to describe the size of the wound repaired.

Returning to Example 2, the 2.5 cm repair is reported 13131. If the wound had been 3.5 cm long, the proper code would be 13132 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm*. If the wound had been 10 cm long, proper coding would be 13132, describing the first 7.5 cm, and +13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)* to account for the remaining 2.5 cm. If the wound had been 16 cm long, proper coding would be 13132 and 13133 x 2 (7.5 cm + 5 cm + 3.5 cm), and so on.

Be Sure Repair Codes Apply

Per CPT®, repairs (closures) as reported with 12001-+13153 may be performed using "sutures, staples, or tissue adhesives (eg, 2-cyanocrylate), either singly or in combination with each other, or in combination with adhesive strips."

If the physician uses only adhesive strips, however, the repair codes do not apply. Instead, you should report an appropriate evaluation and management service code, as determined by the key elements of history, examination, and medical decision-making (or, by time if counseling and coordination of care dominate the patient encounter, and both the time and content of the visit are clearly documented).

Code Multiple Repairs

Often, the clinician may repair several wounds in a single session. When this occurs, determine the proper coding for each repair individually. Then, check if any repairs of the same complexity are grouped to the same anatomic areas. If so, you should add together the lengths of the similar wounds and report them using a single, cumulative code. "For example," CPT® says, "add together the lengths of intermediate repairs to the trunk and extremities." Do not combine wounds of different severity or those that fall within separate anatomic locations (as defined by the relevant code descriptors).

When reporting several wounds of differing severity and/or location, claim the most extensive (i.e., highest-valued) code as the primary service, and append modifier 59 *Dis-*

tinct procedural service to subsequent repair codes. Multiple procedure reductions will apply for the second and subsequent procedures (except for those procedures reported using an add-on code).

Example 3: The physician repairs four wounds for a patient involved in a fall from a motorcycle:

- Simple repair, 10 cm, left arm
- Intermediate repair, 12 cm, left arm
- Intermediate repair, 15 cm, left leg
- Complex repair, 9.0 cm, left leg

There is a single simple repair, which is reported with 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm*.

The complex repair is also the only one of its type, and is coded 13121 *Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm* for the initial 7.5 cm, along with +13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* for the additional 1.5 cm (7.5 cm + 1.5 cm = 9 cm).

There are two intermediate repairs: Considered separately, you would report them using 12034 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm* and 12035 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm*. Notice, however, that although these are separate wounds, both require intermediate repair, and both are located within the same anatomical category (the extremities). As such, combine the two wounds (12 cm + 15 cm = 27 cm) to report 12036 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm*.

The complex repair is the most extensive procedure and should be first listed. The remaining repairs are reported with modifier 59 appended. Final coding:

13121, +13122

12036-59

12004-59

Multiple procedure reductions will apply to 12036 and 12004 (but not to the primary procedure, or + 13122).

Don't Shortchange the Physician

Detailed physician documentation is critical to determine the complexity and size of the repair(s). Lackluster notes

Wound Repair: What's Bundled, What's Not

Wound repair (closure) may be performed with other, related procedures during the same session. Some of these related procedures may not be separately reported; others may be separately reported, or separately reported only in specific circumstances. Here's a quick rundown, based on CPT® and the Medicare guidelines.

Never reported separately with wound repair/closure:

- Any/all services considered part of the global surgical package (e.g., topical anesthesia, writing orders, immediate/typical postoperative care, etc.) See the Surgical Package definition in the CPT® Surgery Guidelines for complete details. Note that Medicare defines the surgical package differently than does CPT®. See Medicare *Claims Processing Manual*, chapter 12, section 40.1.
- Chemical or electrocauterization of wounds not closed
- *Simple* ligation of vessels in an open wound
- *Simple* exploration of nerves, blood vessels, or tendons exposed in an open wound. More complex exploration may be reported separately (see below).
- For *complex* repairs, "creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions"

Sometimes reported separately with wound repair/closure:

- Decontamination or debridement: CPT® specifies, "Debridement is considered a separate procedure *only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.*" [emphasis added]
- Wound repair does *not* include excision of benign (11400-11446) or malignant (11600-11646) lesions, but lesion excision *may* include would repair. Per CPT®, *simple* repairs are always included in lesion excision, but "Repair by intermediate or complex closure should be reported separately." Medicare, via National Correct Coding Initiative edits, follows the same rules.

Always reported separately with wound repair/closure:

- When associated with *complex* repairs (13100-+13153), excisional preparation of a wound bed (15002-15005), or debridement of an open fracture or open dislocation
- *Complex* repair of nerves, blood vessels, and tendons
- Per CPT®, "If the wound requires enlargement, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s) of the subcutaneous tissue, muscle fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103 as appropriate."

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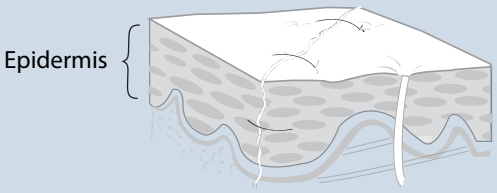
OPTUM



Example of a simple closure involving only one skin layer

12001: 2.5 cm or less
12002: 2.6 to 7.5 cm
12004: 7.6 to 12.5 cm
12005: 12.6 to 20.0 cm
12006: 20.1 to 30.0 cm
12007: more than 30.0 cm

A simple wound of the extremities, including the hands and elsewhere, is repaired. Report wounds according to the length of the lesion. Wounds of similar complexity in the same anatomical area may be summed and reported as a total length

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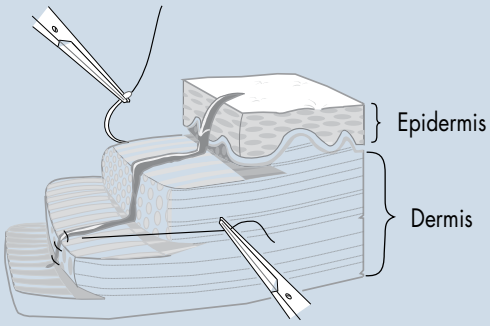
Schematic of layered closure



A layered closure of a wound of the arm, or elsewhere, but excluding the hands is performed

12031: 2.5 cm or less
12032: 2.6 to 7.5 cm
12034: 7.6 to 12.5 cm
12035: 12.6 to 20.0 cm
12036: 20.1 to 30.0 cm
12037: larger than 30.0 cm

Lackluster notes can dramatically affect both coding precision and the physician's bottom line, as the payment difference between the various repair types is significant.

can dramatically affect both coding precision and the physician's bottom line, as the payment difference between the various repair types is significant. For example, for a small (2.0 cm) chest wound:

- A simple repair (12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*) is valued at 0.84 physician work relative value units (RVUs), for an approximate Medicare payment of $21.
- An intermediate repair (12031 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less*) is valued at 2.0 physician work RVUs, for an approximate Medicare payment of $50.
- A complex repair (13100 *Repair, complex, trunk; 1.1 cm to 2.5 cm*) is valued at 3.0 physician work RVUs, for an average Medicare payment of $75.

Source: RVUs and calculated average Medicare payments are from the 2013 National Physician Fee Schedule Relative Value File. Actual Medicare payments vary by geographic location. Private payer reimbursements are determined by contract.

Look out for documentation that lacks relevant detail. If necessary, meet with your physicians and show them the code descriptors, so they know precisely which details are required to code correctly (and to collect all earned payments).

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

Anne Patch, CPC

I've always been interested in the billing side of healthcare. Even while I worked in registration at Fletcher Allen Healthcare in Burlington, Vt., I coded paper admissions from other departments. It didn't take me long to realize there was a lot about the CPT® and ICD-9-CM codebooks I was unfamiliar with. I wanted to know more.

Taking the Plunge

In summer 2007 I signed up for an AAPC coding class. It was a 20-week course, four evening hours per week, intense testing, and every weekend buried in text books. I loved it!

The exam was difficult, and I used every minute of the five-hours. I mouthed to my instructor on the way out, "See you later for the second test." Surprise! Surprise! I was elated to pass on the first try and we celebrated with a party.

Sunny Days Are Here

My husband and I moved to Florida in 2008. One month after applying for billing jobs in my new locale, I received a call from my present employer, offering me a job in urgent care. Four months later, I transferred to billing for five doctors and an advanced registered nurse practitioner. I now bill in the same building for nine doctors and counting.

I love what I do. Every day I look forward to the challenges of explaining to doctors with 25 plus years experience in practice why I chose more specific codes.

My aspirations remain constant: Learn each day; apply my energy; and research and network to become a better coder. I would love to become a Certified Professional Coder-Instructor (CPC-I®), but for now, I am content staying in a very busy job, knowing I made a great move becoming a CPC®.

By Jeanne L.L. Plouffe, AS, CPC, CGSC

Gallbladder Disease:

Remove the Uncertainty Surrounding Treatment

Key terms in the report will help you code.

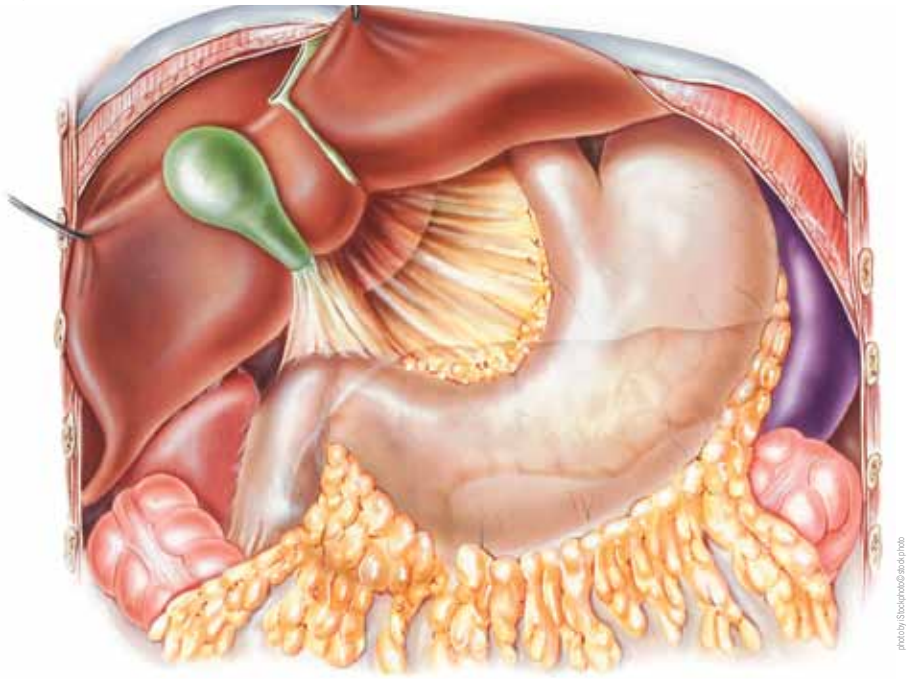


photo by iStockphoto/© alex.gl hob

The gallbladder is a glandular sac located under the liver. Its primary function is to store and concentrate bile produced by the liver. Before a meal, the gallbladder is filled with bile, enlarging to the size of a small pear. During a meal, the gallbladder squeezes bile into the small intestine through ducts. The bile (an acid) is essential to proper digestion and absorption of essential fats and nutrients. After a meal, the gallbladder is empty and becomes flat.

When a gallbladder is not functioning properly, the patient may experience many signs and symptoms:

- Pain, primarily on the upper right side of the abdomen, but can radiate to the back
- Pain waking you up at night
- Pain following meals; intolerance of fatty foods
- Burning sensation in the stomach
- Nausea, vomiting
- Diarrhea
- Loss of appetite
- Fever

Abdominal ultrasound is a common test to confirm a diagnosis of gallbladder disease. A patient also may undergo a hepatobiliary iminodiacetic acid (HIDA) scan with cholecystokinin (CCK)—a medication given to determine the gallbladder's ejection fraction (a measure of how much bile leaves the gallbladder when it contracts). An ejection fraction less than 35 percent indicates a nonfunctioning gallbladder.

Code Common Diagnoses

Common examples of gallbladder disease diagnoses (with a crosswalk to ICD-10-CM) are shown in **Table A**.

CPT® Coding for Treatment

There are several treatment options for gallbladder disease, which may be surgical, endoscopic, or nonsurgical. Nonsurgical treatment includes oral medication to dissolve gallstones and, for asymptomatic gallstones, diet and exercise.

Endoscopic treatment includes endoscopic retrograde cholangiopancreatography (ERCP), in which an endoscope passes through the patient's oropharynx, esophagus, and stomach into the small intestine. The ampulla of Vater is cannulated; contrast fills this area, allowing visualization of the common bile duct and the whole biliary tract, including the gallbladder.

Codes describing ERCP include:

43264 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts; and

43265 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method.

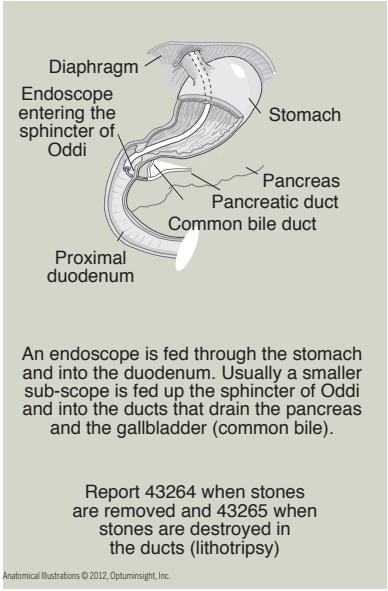
There are several treatment options for gallbladder disease, which may be surgical, endoscopic, or nonsurgical.

Per CPT® instructions, you may separately report radiological supervision and interpretation using:

74328 Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation;

74329 Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation; or

74330 Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation.



For example, a patient is admitted to the hospital with epigastric pain with nausea, vomiting, and jaundice. Lab results show the patient has elevated bilirubin (a brownish-yellow substance found in bile) and high levels of amylase and lipase (enzymes produced by the pancreas). Ultrasonography shows gallstones with dilated bile duct. A gastroenterologist performs an ERCP with removal of stones from biliary and pancreatic ducts.

CPT® coding is 43264 and 74330-26. Modifier 26 *Professional component* is added to 74330 to alert the payer that the physician is billing only his or her portion of the service (the facility providing the radiology equipment and staff will report the technical component of the service).

Surgical Treatments

Surgical treatment of gallbladder disease may include either laparoscopic or open cholecystectomy (note that when a laparoscopic procedure is converted to an open procedure, you should report only the definitive, open procedure).

Table A: Common examples of gallbladder disease diagnoses (with a crosswalk to ICD-10-CM)

ICD-9-CM		ICD-10-CM	
574.00	Cholelithiasis; calculus of gallbladder with acute cholecystitis; without mention of obstruction	**K80.00**	Calculus of gallbladder with acute cholecystitis; without obstruction
574.10	Cholelithiasis; calculus of gallbladder with other cholecystitis; without mention of obstruction	**K80.10**	Calculus of gallbladder with other cholecystitis; without obstruction
574.20	Cholelithiasis; calculus of gallbladder without mention of cholecystitis; without mention of obstruction	**K80.20**	Calculus of gallbladder and bile duct with acute cholecystitis; without obstruction
574.30	Calculus of bile duct with acute cholecystitis; without mention of obstruction	**K80.42**	Calculus of bile duct with acute cholecystitis; without obstruction
574.40	Calculus of bile duct with other cholecystitis; without mention of obstruction	**K80.44**	Calculus of bile duct with chronic cholecystitis; without obstruction
574.60	Calculus of gallbladder and bile duct with acute cholecystitis; without mention of obstruction	**K80.62**	Calculus of gallbladder and bile duct with acute cholecystitis; without obstruction
575.0	Acute cholecystitis; without mention of calculus	**K81.0**	Acute cholecystitis; without mention of calculus
575.10	Cholecystitis, unspecified	**K81.9**	Other cholecystitis, unspecified
575.11	Chronic cholecystitis	**K81.1**	Chronic cholecystitis
575.12	Acute and chronic cholecystitis	**K81.2**	Acute and chronic cholecystitis
575.3	Hydrops of gallbladder	**K82.1**	Hydrops of gallbladder
575.6	Cholesterolosis of gallbladder (strawberry gallbladder)	**K82.4**	Cholesterolosis of gallbladder (strawberry gallbladder)
575.8	Biliary dyskinesia	**K82.8**	Other specified disorders of gallbladder

There are over 40 possible code selections available in the biliary tract portion of the CPT® codebook; and yet, there may be an occasion when none of the codes accurately describe the surgery performed.

During laparoscopic cholecystectomy, four small incisions are made in the abdomen and laparoscopic instruments are used to remove the gallbladder.

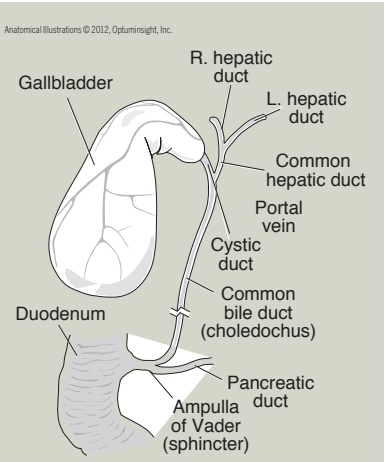
CPT® codes include:

47562 Laparoscopy, surgical; cholecystectomy

47563 cholecystectomy with cholangiography

47564 cholecystectomy with exploration of common duct

47570 cholecystoenterostomy



The gallbladder is removed in a laparoscopical surgical session (47562). Any method of removal may be employed. Report code 47563 when a contrast agent is injected into the cystic duct and an image taken in order to identify stones or strictures

Report code 47564 when the common bile duct is explored in the course of the laparoscopic session

Note: Diagnostic laparoscopy (47560 *Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy*) is included in surgical laparoscopy.

For example, a primary care physician refers a patient to a general surgeon for possible gallbladder surgery. The patient presents with results from abdominal ultrasound, which shows cholelithiasis (ICD-9-CM 574.20). Surgery is recommended. The resulting operative report documents:

> *After induction of anesthesia, an incision was made. Subumbilical Veress needle inserted and insufflation of abdomen performed. After adequate insufflation, trocars were inserted. Gallbladder was grasped and withdrawn over liver. Cystic duct delineated, clipped on the gallbladder side and incised. Digital fluoroscopic cholangiography revealed no intraluminal defects or obstruction. Cystic duct triply clipped and transected. Gallbladder resected from liver bed and removed through xiphoid port.*

In this case, the correct CPT® codes are 47563 and 74300-26. The postoperative diagnosis is cholelithiasis with acute cholecystitis (ICD-9-CM 574.00). Because the pre- and postoperative diagnoses are different, you should wait for the pathology report before assigning a final diagnosis code.

"Open" cholecystectomy involves making an incision on the right side of the abdomen, under the rib cage, through which the gallbladder is removed.

CPT® codes include:

47600 Cholecystectomy;

47605 with cholangiography

47610 Cholecystectomy with exploration of common duct;

47612 with choledochoenterostomy

47620 with transduodenal sphincterotomy or sphincterplasty, with or without cholangiography

There are over 40 possible code selections available in the biliary tract portion of the CPT® codebook; and yet, there may be an occasion when none of the codes accurately describe the surgery performed. When this occurs, turn to 47999 *Unlisted procedure, biliary tract* for open procedures and 47579 *Unlisted laparoscopy procedure, biliary tract* for laparoscopic procedures.

For example, a general surgeon provides a consult for a patient in the hospital with acute upper right quadrant abdominal pain radiating to the back. The patient undergoes a HIDA scan with CCK, which shows an ejection fraction of 18 percent. The preoperative diagnosis is acute cholecystitis (ICD-9-CM 575.0). Due to the patient's previous abdominal surgical history, an open procedure is recommended. The resulting operative report states:

> *After induction of anesthesia a subcostal incision was made on the right side. Skin and subcutaneous tissue were incised, rectus fascia incised, rectus muscle transected, and peritoneum entered. The gallbladder was grasped and withdrawn over the liver. The dissection was carried down retrograde in the gallbladder bed using electrocoagulation. The cystic duct identified, clamped transected and tied with 2-0 silk. The gallbladder was removed, subcostal incision closed and sutured.*

In this case, you would report CPT® 47600. The pathology report diagnosis is acute and chronic cholecystitis (ICD-9-CM 575.12). Again: Because pre- and postoperative diagnoses are different, you should wait for pathology before assigning a diagnosis code.

Remember: The op report is a road map that will guide you to the appropriate procedure code(s). Educating your physicians and yourself on the key elements needed in an op report is essential in selecting the most appropriate CPT® codes (regardless of specialty).

Jeanne L.L. Plouffe, AS, CPC, CGSC, has over 30 years of experience in specialty coding and reimbursement. She has dedicated more than 20 years of her career to general and vascular surgery coding challenges. Plouffe is coding and compliance manager, PCMG division at Phoenix Children's Hospital. She and her staff are responsible for coding and education for more than 230 providers in more than 15 different specialties. Plouffe is a frequent speaker for local chapters in Arizona, has presented at AAPC national conferences, and is a member of the Phoenix, Ariz., local chapter.

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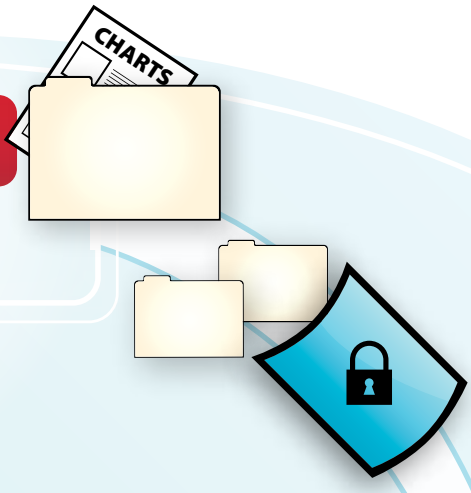

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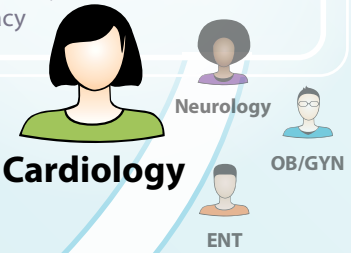

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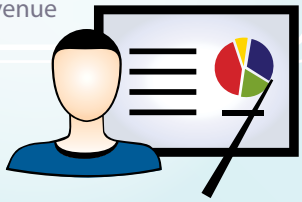

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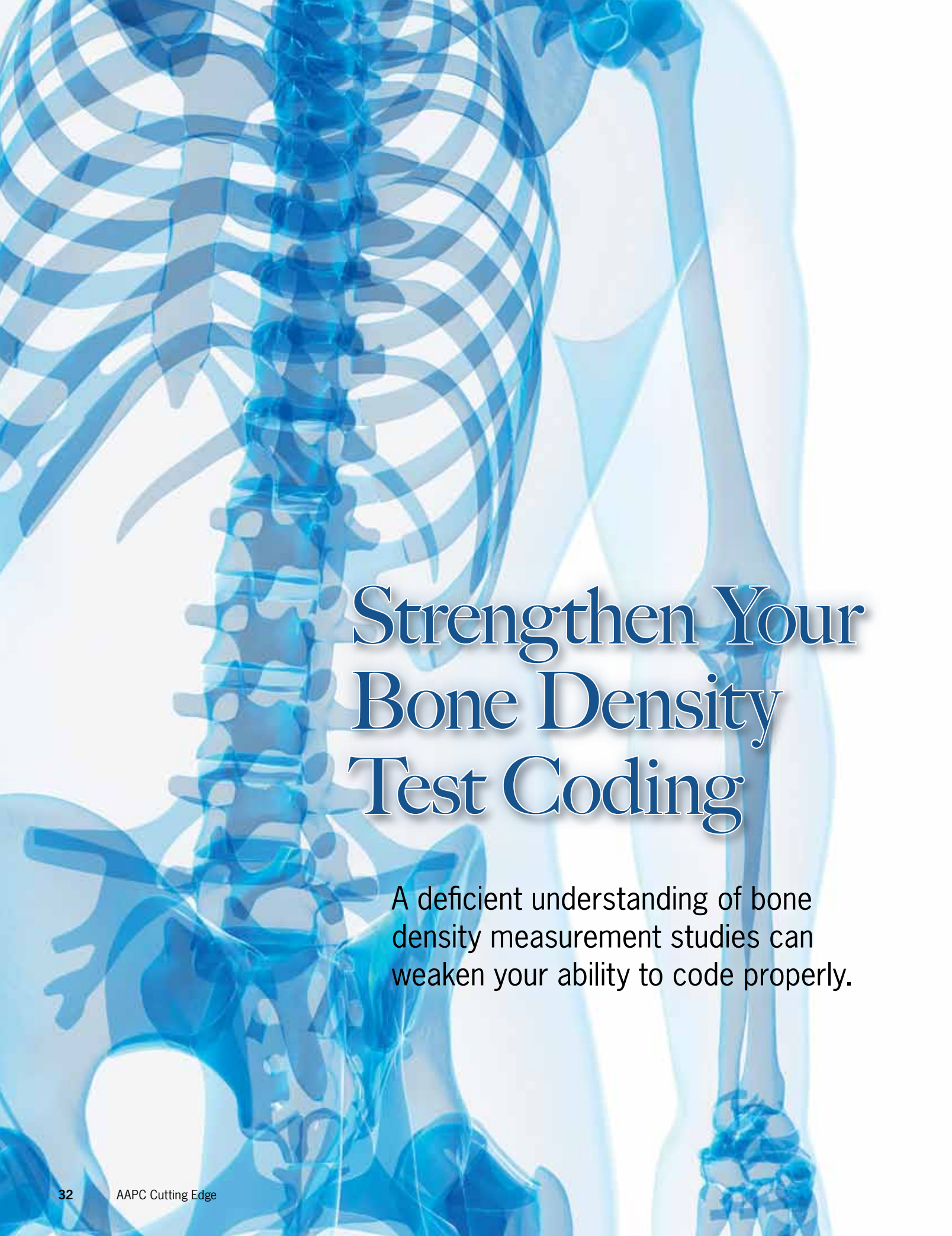


Strengthen Your Bone Density Test Coding

A deficient understanding of bone density measurement studies can weaken your ability to code properly.

By Ken Camilleis, CPC, CPC-I, CMRS, CCS-P

Bone density studies measure specific mineral values in targeted bony structures throughout the skeletal system, which allows a physician to diagnose osteoporosis (porous bone) or osteopenia (low bone density, the precursor to osteoporosis).

Is the Service Warranted?

Indications that warrant a bone density study vary. The National Osteoporosis Foundation (NOF), for example, recommends bone density testing under the following conditions:

- You are a woman age 65 or older
- You are a man age 70 or older
- You break a bone after age 50
- You are a woman of menopausal age with risk factors
- You are a postmenopausal woman under age 65 with risk factors
- You are a man age 50-69 with risk factors

Or a physician might order a bone density study for a patient who has had:

- An X-ray showing a spinal break or bone loss
- Back pain
- Loss of height more than 1/2 inch within one year
- Loss of height more than 1-1/2 inches from original height

Age is a key factor because the older a person gets, the more bone he or she tends to lose (reflected in ICD-9-CM classification as "Senile," and in ICD-10-CM as "Age-related"). Gender is also a factor. Women are more prone to osteoporosis because they have smaller bones than men. Menopause can increase this risk as estrogen levels drop.

Based on a U.S. Preventive Services Task Force (USPSTF) recommendation, osteoporosis screening is available as a covered preventive service under the Affordable Care Act only for women aged 65 years or older, and in younger women whose fracture risk is equal to or greater than that of a 65-year-old woman who has no additional risk factors. The USPSTF says there is insufficient evidence to support screening for osteoporosis in men. Private payer policies may differ, so always check a patient's coverage.

Bone Density Studies: A Primer

The most common, accurate method to measure bone density involves dual energy X-ray absorptiometry (DXA). DXA projects two X-ray beams to better assess bone density and can detect a variance as small as 3 percent from one scan to the next. Conventional X-rays are not sensitive enough to detect such small variances. DXA is especially effective for full-body skeletal assessments, as well as for focused studies of the hip, spinal column, and forearm (the skeletal areas most likely to break).

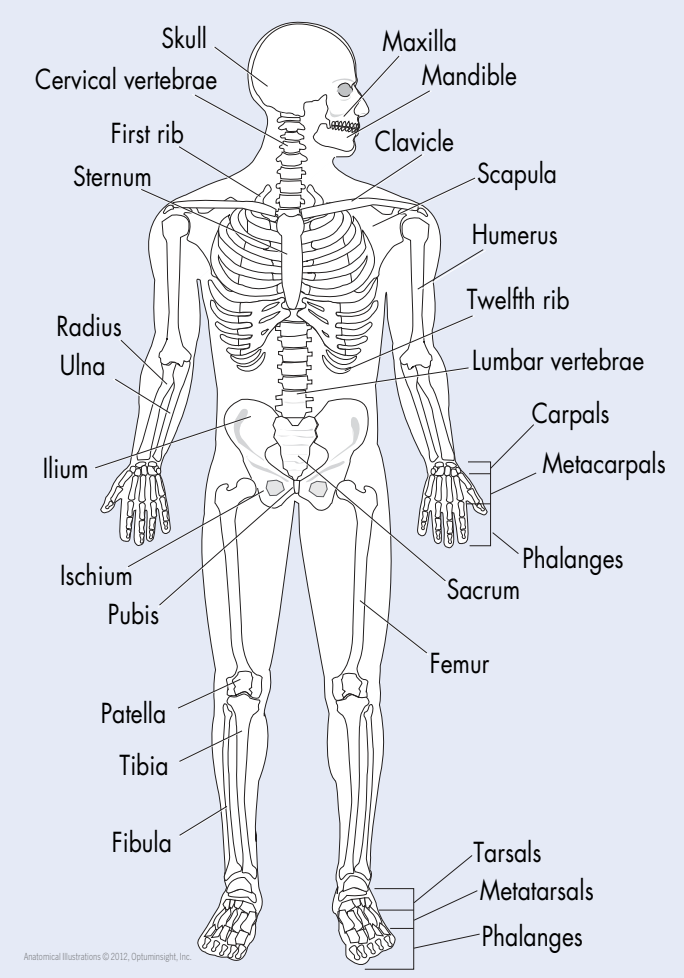
During a DXA scan, the patient rests on a cushioned platform. Mechanical arms are placed under the X-ray table and are aligned with an X-ray detector placed above the patient's body. The amount of X-ray energy absorbed by the bone is measured to determine the strength of that bone. Less energy will pass through healthy bone than through osteopenic or osteoporotic bone.

Bone Marker Tests

Bone marker tests analyze the composition of bone at two (or more) intervals, based on how old bone is broken down by osteoclasts and new bone is formed by osteoblasts. Bone marker tests can evaluate bone loss based on the rate of change observed from one reference point (test date) to the next, but are not a substitute for bone density tests because they do not detect osteoporosis.

Aside from using DXA, a bone density study might be conducted using:

- Peripheral DXA (pDXA) – Portable machines used to measure bone density in the arms or legs.
- Quantitative computed tomography (QCT) – This type of CT scan measures bone density in the spine.
- Peripheral QCT (pQCT) – This type of CT test measures bone density in the arms or legs.
- Dual photon absorptiometry (DPA) – This test uses a radioactive substance to measure bone density in the hip and spine.
- Quantitative ultrasound (QUS) – A portable machine used to measure bone density of the heel.
- Radiographic absorptiometry (RA) – This technique is most commonly used for bone density measurement at the hand or heel.



Analyze the Results

At the end of the bone density report, a summary graph compiles all of the data gathered into statistics for all regions examined in the study, tabulating each bone density, T-score, and Z-score. T- and Z-scores are baseline bone-specific values calculated based on guidelines published by the World Health Organization (WHO). The T-score is further influenced by statistics compiled by the NOF.

T-scores indicate whether there is normal bone strength, osteopenia, or osteoporosis:

Bone Density Measurements

T-score	What it means
-1 and above	Normal
Between -1 and 2.5	Osteopenia
-2.5 and below	Osteoporosis

* A T-score higher than +1.0 indicates healthier than average bone for the patient's age.

Z-scores may assist in diagnosing secondary osteoporosis by calculating a value that takes into consideration the patient's age and how he or she compares to an age-appropriate peer group with normal health in the bone being analyzed. According to WHO guidelines, a Z-score less than -1.5 is a red flag for further workup to diagnose or rule out secondary osteoporosis. The lower the Z-score, the more likely another factor besides the normal aging process is the cause of premature bone loss.

CPT® Coding for Bone Density Studies

Bone mineral density tests are reported with CPT® 77078 *Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)*, while DXA tests are coded according to site using the following CPT® codes:

77078 Computed tomography, bone mineral density study, 1 or more sites; axial skeleton

77080 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

77081 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel).

77082 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment

76499 Unlisted diagnostic radiographic procedure

A bone density measurement and interpretation by ultrasound is reported with CPT® 76977 *Ultrasound bone density measurement and interpretation, peripheral site(s), any method*. Laboratory tests, such as those to assess calcium (82310-82340), iron (83540), magnesium (83735), and phosphate (84100-84105) also figure into the CPT® mix during patient care in maintaining or improving bone health.

ICD-9-CM Reporting

Common diagnoses resulting from bone density studies may be reported with the following ICD-9-CM codes from Category 733 *Other disorders of bone and cartilage*:

733.0x Osteoporosis

733.1x Pathologic fracture

733.9x Other and unspecified disorders of bone and cartilage

Bone pain and other bone disorders may be coded from Category 719 *Other and unspecified disorders of joint;* or

... a Z-score less than -1.5 is a red flag for further workup to diagnose or rule out secondary osteoporosis.

733.90 Disorder of bone and cartilage, unspecified.

Report personal or family history of bone disorders with:

V13.89 Personal history of other specified diseases;

V17.81 Family history of osteoporosis; or

V17.89 Family history of other musculoskeletal disease.

Example 1: A 59-year-old man presents to his primary care physician (PCP) with the chief complaint of creaking knees: His knees ache and pop every time he rises from his living room sofa. He also has heard and felt occasional snaps in his groin and shoulder blades. The PCP does a limited exam of these three regions and orders bilateral X-rays of these regions.

CPT® codes:

- Established patient, expanded problem-focused history and exam, low-complexity medical decision-making (MDM): 99213
- Bilateral knee X-ray: 73565-26
- Bilateral hip X-ray: 73520-26
- Bilateral shoulder X-ray: 73050-26

Note that modifier 26 *Professional service* is applied to describe this as a physician (as opposed to a facility) service.

ICD-9-CM codes:

- Creaking knees: 719.66

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Repeat bone density studies may be ordered to assess improvement or exacerbation of bone weakness ...

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- Creaking hips: 719.65
- Creaking shoulders: 719.61

Example 1, continued: The knee X-rays reveal a cartilaginous abnormality, and nothing can be concluded from the hip and shoulder X-rays (they appear negative). DXA scans are performed on the patient's right and left femur right and left patella, and right and left shoulder. The studies reveal softening of cartilage in both knees, and low bone density scores with corresponding T-scores of -2.7 and -2.6 on the hips and -1.8 and -1.4 on the shoulders.

CPT® codes:

- DXA scans of femur: 77080-26 (report only once for each site in axial skeleton)
- DXA scans of patella and shoulder: 77081-26 (report only once for each appendicular site)

ICD-9-CM codes:

- Chondromalacia of knees: 717.7 (by Excludes note from 733.92)
- Osteoporosis of hip bones: 733.00 (T-score below -2.5 indicates osteoporosis)
- Osteopenia of shoulder joints: 733.90 (T-score between -1.0 and -2.5 indicates osteopenia)

Repeat bone density studies may be ordered to assess improvement or exacerbation of bone weakness and to evaluate how a patient's bone structure is responding to treatment.

Reporting Bone Density Deficiency Using ICD-10

In ICD-10-CM, codes from categories M80 through M85 indicate "Disorders of bone density and structure." Some notable subcategories are:

M81.0	Age-related osteoporosis without current pathological fracture
M81.6	Localized osteoporosis [Lequesne]
M83.-	Adult osteomalacia
M84.3-	Stress fracture
M85.0-	Fibrous dysplasia (monostotic)
M85.8-	Other specified disorders of bone density and structure

The codes in most of these subcategories are vastly expanded compared to ICD-9-CM in terms of specific bone disorder, anatomic site, and laterality. Subcategory M85.8- includes anomalies such as osteopenia, hyperostosis, and osteosclerosis, and is also site-specific and laterality-specific.

In ICD-10-PCS, you'll find the main term "densitometry" in the Imaging section as a seventh-character qualifier within codes beginning with BP4, BQ0, and BR0. These represent inpatient facility components of ultrasound on non-axial upper bones and plane radiography on non-axial lower bones, as well as most of the axial skeleton.

Ken Camilleis, CPC, CPC-I, CMRS, CCS-P, is an educational consultant and PMCC instructor with Superbill Consulting Services, LLC. Camilleis is the new member development officer of Massachusetts' Quincy Bay Coders local chapter.

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

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

Due to the clinical nature of ICD-10-CM—the diagnosis code set the healthcare industry will begin using Oct. 1, 2014—a strong understanding of anatomy and physiology (A&P) will be required for accurate reporting of patients' medical conditions.

What does the abbreviation OI stand for in medical terms?

a. Ongoing illness

b. Opportunistic infection

c. Opportunistic illness

d. Ongoing infections

Check your answer on page 65.

Take this monthly quiz, in addition to AAPC's ICD-10 Anatomy and Pathophysiology advanced training, to prepare for the increased clinical specificity requirements of ICD-10-CM. To learn more about AAPC's ICD-10 training, go to http://cloud.aapc.com/documents/AAPC%20ICD10%20Service%20Offerings.pdf to download AAPC's ICD-10 Service Offering Summary.

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC. She is a member of the Oil City, Pa., local chapter.

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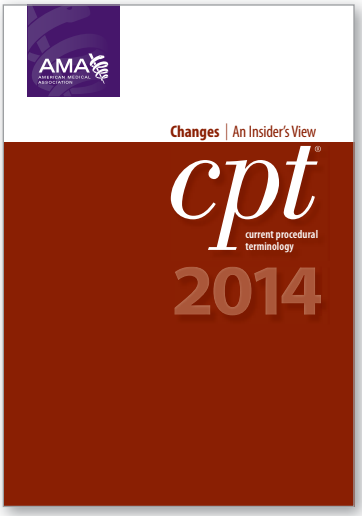

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By Robert A. Pelaia, Esq., CPC, CPCO, and Rosanne Brandt, DDS

Coding Compass

Don't Enter the Exclusion Zone

Know how to avoid the consequences of employing anyone on the OIG's "list."

In May 2013, the Office of Inspector General (OIG) issued the "Updated Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs." The updated bulletin expands and clarifies the scope and effect of legal prohibition on payment by federal healthcare programs for items or services furnished by an excluded person, or at the medical direction of or prescribed by an excluded person. It describes how you can violate the prohibition, and the administrative sanctions OIG can pursue against the prohibition violators. It also provides guidance on the screening of employees or contractors to determine whether they are an excluded person.

To protect patients and eliminate fraud, waste, and abuse in federal healthcare programs, the OIG has the authority to exclude certain providers from participation in federal healthcare programs. Some common reasons for federal healthcare program exclusion include convictions of fraud, patient abuse, and licensing board actions, such as revocation of a medical license due to concerns over physician competence. Federal law also authorizes civil money penalties (CMPs) against healthcare providers or entities that employ or contract with an individual or entity, which they know or should know is excluded from participation in a federal healthcare program, and that provide, either directly or indirectly, federally reimbursed items or services.

Effects of Exclusion

Exclusion from federal healthcare programs means no payment will be made for items or services furnished, ordered, or prescribed by an excluded provider. Items or services furnished at the direction or prescription of an excluded individual or entity also are not reimbursable when the party furnishing the items or services either knows, or should know, of the exclusion. Healthcare providers and entities may not employ or contract with an excluded individual to provide items or services paid for by a federal healthcare program.

Photo by iStockphoto/DaxiaJi

Limited exceptions do exist that allow excluded individuals to be paid for certain services, such as emergency services.

The duration for exclusion may be time limited or permanent. At the conclusion of a time-limited exclusion, an excluded provider may apply for reinstatement in a federal healthcare program, and the OIG may approve the application. Limited exceptions do exist that allow excluded individuals to be paid for certain services, such as emergency services.

Examples of Prohibited Situations

To help providers recognize situations where employment of an excluded person is prohibited, the following examples are mentioned in OIG's updated 2013 bulletin. In all of these examples, the employer may be subject to overpayment and CMP liability for violations of federal law.

- Hospital will not be paid for the items or services furnished by an excluded nurse to federal healthcare program beneficiaries, even if the nurse's services are not separately billed and are paid for as part of a Medicare diagnosis-related group payment received by the hospital. The excluded nurse also would be in violation of her exclusion for causing a claim to be submitted by the hospital for items or services he or she furnished while excluded.
- Federal healthcare program payment is prohibited for items and services provided by a person who was excluded as a pharmacist—even after that person earns his or her medical degree and becomes a licensed physician.
- Federal prohibition of healthcare program payment applies to services performed by excluded individuals who work for (or under an arrangement with) a hospital, nursing home, home health agency, or managed care entity when such services are related to, for example, preparation of surgical trays or review of treatment plans—regardless of whether those services are separately billable or are included in a bundled payment.
- No federal healthcare program payment is allowed for services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs that are billed to a federal healthcare program.
- Excluded individuals are prohibited from providing transportation services (e.g., ambulance driving, ambulance dispatching, etc.) that are paid for by a federal healthcare program.
- Excluded persons are prohibited from furnishing administrative and management services payable by federal healthcare programs. This prohibition applies even if the administrative and management services are not separately billable. For example, an excluded individual may not serve in an executive or leadership role (e.g., chief executive officer, chief financial officer, general counsel, director of health information management, director of human resources, physician practice office manager, etc.) for a provider that furnishes items or services payable by federal healthcare programs.
- An excluded individual may not provide other administrative and management services, such as health information technology services and support, strategic planning, billing and accounting, staff training, and human resources, unless wholly unrelated to federal healthcare programs.
- Any items and services are not payable by a federal healthcare plan when furnished at

Relying on a staffing agency to check the exclusion status of all potential employees will not avoid CMP liability.

the medical direction of, or prescribed by, an excluded person when the person furnishing the items or services either knows or should know of the exclusion. Many providers (e.g., laboratories, imaging centers, durable medical equipment suppliers, and pharmacies, etc.) could be subject to liability if they furnish items or services to a federal program beneficiary on the basis of an order or a prescription that was written by an excluded physician. To avoid liability, the OIG encourages providers to ensure, at the point of service, that the ordering or prescribing physician is not excluded.

CMP Liability

Employment of excluded providers results in submission of overpayments that trigger CMP liability if the excluded person provides services payable, directly or indirectly, by a federal healthcare program. If a healthcare provider contracts with or employs an individual that the employer knows or should know is excluded, the provider may be subject to a CMP of up to $10,000 for each item or service, as well as an assessment of up to three times the amount claimed, in addition to program exclusion.

CMP liability applies to furnishing items or services that are OIG exclusion violations. Such exclusions include direct patient care, administrative and management services, and items or services furnished at the direction of an excluded individual—even if the excluded person does not receive payment for the furnished items or services. Liability also applies to any excluded individual regardless of whether the individual is an employee, contractor, volunteer, or any other relationship with the provider. Relying on a staffing agen-

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Although there is no statutory or regulatory obligation to search the LEIE, it's advised that providers make use of this valuable resource.

cy to check the exclusion status of all potential employees will not avoid CMP liability. The OIG points out that even if another entity is hired to check the exclusion status of potential employees, the provider retains the potential CMP liability if they employ or contract with an excluded individual.

Sources of Excluded Information

The OIG maintains a list of all current excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). The LEIE is available on the OIG website (www.oig.hhs.gov/exclusions) and is updated monthly. The OIG recommends that providers check the list to identify excluded individuals. The OIG sends its list of excluded parties to the Centers for Medicare & Medicaid Services (CMS) (to update its Medicare Exclusions Database: http://exclusions.oig.hhs.gov/) and to the General Services Administration, which maintains an Excluded Parties List System.

State sanctions and licensure databases are another source of exclusion information, but the OIG recommends the LEIE as the primary database for purposes of screening current and potential employees and contractors.

Take Steps to Reduce Liability

Perhaps the most valuable instruction to providers is to use the OIG's LEIE to screen not just employees, but also contractors, subcontractors, volunteers, and other personnel who may provide services or items payable by a federal healthcare program. Although there is no statutory or regulatory obligation to search the LEIE, it's advised that providers make use of this valuable resource.

Check all potential names. When checking names against the LEIE, all potential names used by the individual should be searched (including maiden names) because only the name known to the OIG at the time of exclusion is included in the database. If you find a potential match, you must try to verify the results. It is not sufficient to simply find a matching first and last name on the LEIE.

Check for status changes. The OIG also recommends that employers periodically check all employees and contractors against the LEIE to determine whether their status has changed. Other groups highly recommended for screening by the OIG are: employees provided by staffing agencies, physician groups that contract with the hospital to provide emergency room coverage, and billing or coding contractors.

The basis behind these additional screenings is that CMP liability risk is greatest for those providers who cause claims to be submitted to federal healthcare programs for payment of items or services integral to the provision of patient care. If a provider does not periodically rescreen employees and contractors, he or she may be subjected to additional penalties if the OIG determines he or she would have known about the exclusion sooner had a periodic screening been done.

It's vitally important to comply with the prohibition on payment by federal healthcare programs for items or services furnished by excluded persons or at the medical direction of or prescribed by an excluded person. Providers could save substantial money by knowing the rules and carefully ensuring no prohibited arrangements are entered into. It's advisable, and necessary, for employers to institute a screening program to identify excluded individuals as quickly as possible and avert potential (and easily avoidable) liability.

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By Barbara Cataletto, MBA, CPC

Take a Refresher on Coder Liability

What you don't know can hurt you.

In addition to acquiring all the necessary tools and education needed to code and bill, you also are responsible to adhere to regulations governing reimbursement. Failure to perform these duties may result in a direct violation of contractual and professional obligation.

Understand Areas of Risk

Key areas of coding violations, according to the federal government and national coding certification programs, are:

Participating in, agreeing to, or hiding improper coding, knowing that it's improper coding

If you purposefully involve yourself in supporting fraud, your liability can be enormous. If you feel fraud is committed, document the process that you believe is a violation and present this to your superiors or clients to promote dialogue and correction. If you do not get results that protect you, look for a new position somewhere else.

Billing for items or services not actually documented

Before you push the fraud component here, communicate with the healthcare provider to make sure you are certain the items are properly documented as required. Educate the provider about the documentation requirements needed to support the billing.

Unbundling

This occurs when a billing entity uses separate billing codes for services with an aggregate billing code. This area of coding requires a great deal of scrutiny because payers use several resources (e.g., National Correct Coding Initiative edits, CPT® guidelines, etc.). The practice or facility must abide by regulated industry standards throughout the billing process.

Never ignore an overpayment or refund request, but do not refund blindly.

Upcoding

Upcoding is billing a code that provides a higher reimbursement rate than the code that accurately reflects the level of service performed on the patient. The greatest revenue is generated with the highest-level coding possible, but don't be persuaded to push the limit by upcoding. If you can't appeal it, you shouldn't code it.

Inappropriate balance billing

This is billing Medicare beneficiaries for the difference between the provider's fee and the Medicare Part B allowable payment.

If you are contracted with carriers, most patient balances for contractual agreement are identified on the explanation of benefits. In most cases, it is inappropriate to bill patients for items not covered or approved. Be cautious of billing for patient balances that you think should have been covered, but weren't approved, or were bundled into other procedures. Perform the appropriate appeal for charges you believe were denied unjustly.

Inadequate resolution of overpayments

This means accepting improper or excessive payment as a result of patient billing or claims processing errors. Never ignore an overpayment or refund request, but do not refund blindly. Always respond in writing and ask the carrier to provide an acceptable explanation as to why a refund is justified. Be prepared to appeal if you believe the request is unjustified.

Know Your Potential Criminal Exposure

Remember that you have made a commitment to be ethical and moral, to follow industry guidelines and standards, and to continue your education. As a professional, you know the importance of being fully informed of any changes in the ever-evolving coding world. Education is readily available through AAPC and a variety of specialty education providers.

Although honest mistakes and omissions can occur in every business, it's important for the integrity of the coding profession and the healthcare industry to remain mindful of all acceptable coding and billing practices. Compliance programs and continued education will help you reduce unintended violations and provide an outlet to report violations, if they occur.

Even if you received no compensation, did not actually perform the improper coding, and fear for the loss of employment, you should expose criminal behaviors. You can do this by reporting anonymously to the insurance boards of your state, directly to the carrier, etc. Failure to report such crimes may result in accessory charges by officials. Be sure to protect yourself and the patients involved by being proactive and responsible.

In the end, you are ultimately responsible for yourself. As Shakespeare said in act 1, scene 3 of Hamlet:

"This above all—to thine own self be true,
And it must follow, as the night the day,
Thou canst not then be false to any man."

These were wise words then and they are wise words now.

Barbara Cataletto, MBA, CPC, is CEO and founder of Business Dynamics, Inc. She is considered an expert in spine coding and reimbursement, and sits on the International Society for the Advancement of Spine Surgery Coding Task Force and Adelphi University's Robert B. Willumstad School of Business board of advisors, has received a National Stevie Award, and was most recently named one of the 50 Most Influential Women in Business on Long Island, N.Y. Cataletto is a member of AAPC's Jamaica, N.Y., local chapter. For more information about Business Dynamics RCM, an affiliate of Business Dynamics, Inc., please visit their website at www.businessdynamicsrcm.com. For more information about The Business of Spine, visit their website at www.thebusinessofspine.com.

By Sarah Hobson, CPC, CPC-H, CPC-P, CPMA, CANPC

Don't Fumble Your Audit

Dodge these five pitfalls to stay sure-footed during a medical claims audit.

An official letter arrives in the mail saying you're being audited. If this hasn't happened to you yet, it will. And when it does, don't panic. Take a few minutes to huddle with your co-workers and think about what you can do to make sure your office passes muster. Begin by building a good defense; and from an auditor's perspective, avoid the following top ways to fumble an audit.

No. 1: Not Responding

The worst mistake you could make is not responding to the audit request. Lack of response will be interpreted as lack of interest (you just don't care)—or, even worse, that you know you can't pass the audit. If you don't respond to the request, you can expect another audit letter within six months. And if you don't respond to that, you might as well cut the insurance company a check for the claims payment.

Avoidance Tip: Read the letter carefully. The insurance company may tell you which specific claims they're auditing or they may just be letting your office know they intend to audit in the near future. If you're not clear on what's happening, call the insurance company's contact person and ask. There should always be a contact name and number or email on the letter. Insurance companies prefer you ask questions than not respond at all.

No. 2: Incomplete Records

Another big way to invite trouble is to send incomplete records. Chances are you don't need to send the entire patient chart. Send only the requested information. If the insurance company wants to see records for the date of service 03/17/13, double-check with your billing system to see what claims were submitted. You may need to get records for services that were billed by your provider, but not necessarily done in the office. For example, the claims in question may be for outpatient services your physician performed in an emergency room, or inpatient surgical services he or she performed at a hospital.

Avoidance Tip: Again, if you need more details on what the auditor is looking for, call and ask. Make sure you're calling the actual auditor, not your unofficial insurance contact (he or she may not be involved). Check your billing system and verify whether you have records for all billed services (paid or not). Request the records you don't have copies of, such as those held at a hospital or other facility. Last but not least: Be sure the patient's name and other identifying information (such as date of birth or date of service) is on each page submitted. Printing from online transcription or getting your documentation from an electronic health record (EHR) doesn't override this requirement. You might need to handwrite the name and other indentifying information on every page.

No. 3: Illegible Records

The golden rule is "not documented, not done." The same

Photo by iStockphoto © Andrey Popov

Insurance companies prefer you ask questions than not respond at all.

thing goes for legibility: If an insurance company can't read your records, they can't audit them. And if they can't audit them, they can't give you credit for the services performed.

Avoidance Tip: Perform a legibility test in the office if you're not using transcription or an EHR. Be sure the average biller can read what the provider documented. If not, consider having the note transcribed or typed. The same thing goes for signatures. A legible provider signature is a "must have." Payers need to know that the billing provider matches the performing provider. If multiple providers in your group handwrite their signatures or initials, consider creating a signature log that shows the full, formal printed name of each provider, his or her full legal signature, and how the signature is abbreviated (such as initials or first initial and last name).

No. 4: Being Unprepared

An audit should not be a surprise to you. Audits are a part of life now, especially with the government (both federal and state) focusing on fraud, abuse, and waste. If you don't already have a plan for how your office keeps copies of documentation and verifies that documentation exists for billed services, right now is a great time to come up with one.

Avoidance Tip: Periodic, internal auditing is the best way to be prepared. If your budget permits, an outside audit consultant is a great way to make sure your results are impartial. If this isn't possible, pull random chart samples based on your billing records. Make sure you have access to appropriate documentation and that billing matches it. You can wait a few days for EHR documentation, transcription, or outside entities to complete their parts, if necessary. Check enough charts to ensure a level of certainty. Document your efforts as part of your compliance plan. This might take a chunk of your time, but efforts now will save you pain later.

No. 5: Not Reviewing the Outcome

Generally, an auditor will prepare a formal response letter or report explaining what he or she found as a result of the audit. Not reviewing the letter or failing to take into consideration the advice within could cause you trouble, especially if the results aren't what you hoped for (in some cases, an audit result can trigger further audits).

Avoidance Tip: Read the report. Don't just file it away. Look for anything that might be helpful to you. For example, the auditor may make recommendations for your practice, such as reviewing ICD-9-CM guidelines or documenting the provider's signature. If you don't understand something, call the auditor and ask for an explanation. If you're provided with an opportunity to answer the audit, use it to bring supporting information to the table that could explain or defend your claims. Bring audit results to your practice staff meetings, as well.

Audits happen for many reasons. It's safe to assume that if your practice hasn't been audited yet, it will be, eventually. These tips won't prevent an audit, but they'll help you reach the finish line without feeling like you were just tackled by a bunch of linebackers.

Sarah Hobson, CPC, CPC-H, CPC-P, CPMA, CANPC, works for a Medicaid Health Maintenance Organization based in Rhode Island and has worked in billing and coding since 1995. She holds a Master of Business Administration from the University of Massachusetts – Lowell, and is pursuing a Master of Science in Health Informatics from Northeastern University. Hobson is a member of the Brandon, Fla., local chapter.

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By Joyce Will, RHIT, CPC

Win the Battle of the Clones

Don't let cloned documentation sink your coding and compliance efforts.

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Although Medicare doesn't have a national policy on the use of shortcuts (such as templates or copy and paste functions) when physicians and non-physician practitioners document services in an electronic health record (EHR), the subject of "cloned notes" continues to be a hot topic in the compliance arena.

Several Medicare administrative contractors (MACs) have published their own opinions as to what constitutes cloning on their websites. For example, J9 MAC First Coast Service Options, Inc., states:

> *Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.*

J11 MAC Palmetto GBA has a very similar opinion:

> *The word "cloning" refers to documentation that is worded exactly like previous entries. This may also be referred to as "cut and paste" or "carried forward." Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.*
>
> *Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.*

Many EHR systems allow providers to set up default or pre-populated templates. Others allow a provider to reuse, or copy and paste, a previous note to make it easier and quicker for the provider to document a patient encounter.

Cloned Documentation Dangers

A downside to using default templates is the potential for outdated (or even incorrect) information to be carried over without being noticed. This, in turn, could create contradictions in the medical record as new information is added during a patient encounter. For example, a default template with a completely negative review of systems (ROS) is used to record an encounter for a patient complaining of cough, sore throat, congestion, and fever. Without effective editing by the provider, the complaints documented in the history of present illness would disagree with the default negative ROS.

Submitting a claim for payment based on cloned documentation—especially if the documentation results in a higher level of service billed—misrepresents the medical necessity of the service. The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) may perceive this as fraudulent billing.

Under the Health Information Technology for Economic and Clinical Health Act, the federal government uses both financial incentives and penalties to encourage physicians to adopt EHRs. Ironically, the same templates, copy and paste features, checkboxes, and macros that are designed to assist physicians in documentation also tend to make each patient encounter appear the same, or cloned, to an outside auditor.

There is an ongoing effort by the federal government to prevent overpayments by Medicare. Scrutinizing the way providers document and bill for services is a large part of this effort. In a Sept. 24, 2012

A downside to using default templates is the potential for outdated (or even incorrect) information to be carried over without being noticed.

letter to the chief executive officers of the American Hospital Association® and others, Attorney General Eric Holder and U.S. Department Health & Human Services (HHS) Secretary Kathleen Sebelius wrote, "A patient's care information must be verified individually to ensure accuracy: It cannot be cut and pasted from a different record of the patient, which risks medical errors as well as overpayments." (www.ama-assn.org/resources/doc/omss/temp/hhs-doj-letter.pdf)

Reviewing EHR documentation of evaluation and management (E/M) services is (once again) included on the OIG Work Plan for 2013 (https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/WP01-Mcare_A+B.pdf). In the work plan, the OIG states it's reviewing multiple E/M services for the same providers and beneficiaries to identify EHR documentation associated with potentially improper payments. The OIG further states that CMS has noticed an increase of medical records with identical documentation across services.

Recently, CMS issued new instructions (change request 8033, issued March 15, www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R455PI.pdf) to MACs, recovery audit contractors, and zone program integrity contractors, in which the use of templates was discussed:

> *CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.*
>
> *Some templates provide limited options and/or space for the collection of information such as by using 'check boxes,' predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.*
>
> *Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.*

Take Action to Avoid Cloning

Whether you review records to assign CPT® and ICD-9-CM codes prior to claim submission or you perform retrospective audits to ensure documentation supports codes submitted for payment, you are in a position to help physicians lessen the risk of cloned medical records. Here are a few things you can do if you identify documentation in the EHR which could be challenged for cloning in an audit.

Avoid copying and pasting. Most commercial EHRs have the ability to copy and paste or reuse a previous note. Talk to your providers and EHR vendor and advocate for turning off the copy and paste functionality. If there is no carry forward of information in the EHR, the chances for contradictions or repetitive errors are greatly reduced.

Understand pre-populated data risks. If your physicians use templates to document their services, make sure they understand the risk of pre-populated data built in to their templates. A better option is for the provider to enter the data at each visit. Often, this can be accomplished with minimal typing by using a "point and click" functionality that adds text to a note. For example, to document an ROS, the physician would click on individual built-in phrases (e.g., denies chest pain or positive shortness of breath with exertion) and that information would be added to the clinic note. A process such as this is not cloning because the provider must actively add the language, as appropriate, for each patient encounter.

Educate and advocate accurate documentation. Unfortunately, anything that is perceived to add to physician work is likely to be a tough sell. If you are met with resistance when recommending changes to the EHR, pick your battles. For example, a provider who refuses to change a pre-populated template should be educated that the language must be read and edited to make it an accurate depiction of the patient's condition at the time of the service.

Physicians and other providers should expect even greater scrutiny of their claims, and the documentation used to support those claims, by government payers. And although the time-saving elements of an EHR may seem advantageous, the responsibility of making sure that the documentation supports an associated claim will continue to lie directly with the service provider.

Joyce Will, RHIT, CPC, has more than 25 years of experience in the areas of ICD-9-CM, CPT®, E/M coding, and professional services compliance reviews. She is a physician services consultant with Health Information Associates, a healthcare consulting firm specializing in coding compliance review, education, and contract coding services. Will is an ICD-10-CM/PCS trainer. She serves as secretary/treasurer for the Mount Juliet, Tenn., local chapter. She can be reached at jwill@hiacode.com.

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By Erin Goodwin, CPC

Get Cozy with Your Insurance Carriers

Build a positive relationship now for effortless resolution later.

Communicating with provider services and getting to know your provider representative on a first name basis is the first step to building a solid relationship with an insurance carrier. If you really want to establish close ties that will weather any storm, you also might consider getting to know the rest of the carrier's staff, too.

Cultivate Resources

Most large insurance carriers have provider representatives responsible for the regions in their area. Call provider services (or get on the provider's website) and find out who your provider representative is, and how to contact him or her. Build relationships now: Don't wait until you have a problem.

Face-to-face meetings are essential in forming good relationships, so it's a good idea to call your provider representative to set one up. Conference calls are impersonal and the participants can often be distracted. People who meet face to face usually form a more meaningful relationship. Many representatives are required to make a certain number of visits per month, and will appreciate you initiating a visit.

Provider representatives have many roles. They can be:

- Educators who help you learn about the insurance carrier's policies, claims processes, or how to use their website
- Claims intermediaries to help you get problem claims adjudicated
- Helpers when you are having authorization issues
- Assistants in contracting and credentialing

I call on my provider representatives for many things. For instance, I call or email them when I find that a policy or procedure has changed, or when provider services gives me conflicting information. I have several representatives who will accept spreadsheets of problem claims that provider services has been unable to help me resolve. My representatives have cleared a path for me when credentialing a new provider, and have kept me up to date on the credentialing process. A representative has even helped me to obtain urgent authorizations when the authorizations department was telling me "three to five business days," but the patient needed the service today or tomorrow.

Work Your Way Up the Chain

Sometimes you may find a provider representative has exhausted his or her resources and is unable to help you, or the problem has reached the point where someone with more influence is needed to take care of the problem. Your representative may recognize when he or she needs to hand the problem over to upper management, but if he or she doesn't, ask your representative if there is someone else who can help you.

If the provider representative's manager is unable to help, you may need to take your issue to the carrier's vice president for your region. If possible, schedule a face-to-face meeting with this person. Your provider representative can usually arrange this, but you may have to be insistent. It will help if you are flexible with the time and place of the meeting.

At the meeting, the first thing the VP will do is hand you a business card. Now you have his or her direct contact information. Score! By the end of the meeting, a relationship has formed. The VP now knows who you are and is more likely to respond to your requests the next time you call. Many times, a VP will introduce you to someone in the claims department who can directly help you with issues. Now that you have an "in," carriers with priority departments might automatically transfer you there to work out issues more expediently.

Relationships Improve Responsiveness

Building relationships takes time and attention, but the ability to resolve issues with a quick phone call or email makes it a worthwhile endeavor. Your provider reps will know who you are, what you need, and will be eager to help you solve any problem as quickly as possible. CE

People who meet face to face usually form a more meaningful relationship.

Erin Goodwin, CPC, is the director of radiation reimbursement at South Carolina Oncology Associates, Pa. She has worked in oncology for over 15 years and is an active member of the Capitol Coders local chapter in Columbia, S.C.

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By Terri Brame, MBA, CHC, CPC, CPC-H, CPC-I, CGSC

Healthy Documentation Starts with You

Form relationships with your physicians that promote communication.

If not handled correctly, communication between coder and physician can be frustrating for both parties. In 15 years working with physicians, I've had as many different physician interactions as I've had physician meetings. I've also learned how to keep the lines of communication open so that everyone in the practice benefits. By keeping a few things in mind, you can make the next meeting with your physicians successful and enjoyable for everyone.

Do Your Part

Unless you are a clinician as well as a coder, avoid making clinical statements when discussing coding and documentation. For example, say to physicians, "I am the CPC® and you are the MD," to be clear that you are not making diagnostic decisions or judgments regarding the care provided. When talking with physicians about coding and documentation, use language that applies to coding and documentation, and not to the clinical work it represents.

The physician is the best arbiter of what work is medically necessary. Avoid statements such as, "You can't spend that much time talking to a patient about X diagnosis," or "That exam element is never done for X chief complaint." It may be that the service was unusual. Your job is to coach the physician in properly documenting his or her services so that you may accurately code them. It is not your job to judge whether the work the physician performed was necessary.

Be a Partner, Not a Policeman

When you first meet with a physician, don't dive right in and start making suggestions for how to change his or her documentation practices. Instead, start the conversation by asking the physician to tell you anything he or she thinks you should know about the practice. A couple of reasons to do this are:

- **Every physician's practice is a little different.** It's good to hear from the physician about the unusual details of the practice before providing coding and documentation recommendations. That way, you won't waste the physician's time talking about things that don't apply specifically to his or her practice. For example, if you have only 30 minutes with a physician, you're doing the physician and yourself a disservice by spending 10 minutes talking about hospital services if your physician doesn't see patients in the hospital.
- **It's an opportunity to learn the business of healthcare.** You can better apply coding and documentation rules if you understand how the practice operates. This understanding also can create a feeling of partnership between the physician and you.

During the meeting, try to keep an open dialogue. Do not speak at physicians; talk with them. As you're providing guidance, check in with them: Does this make sense for the practice? Does it fit with your documentation habits? If not, work with your physician to determine how to make his or her practice and the rules for coding and documentation coincide. Be ready to think creatively about how best to achieve this.

Make it clear that you want your physician to collect all of the reimbursement he or she is appropriately due, and you want to minimize any risk to the practice. The physician's success is your success. Your interest is making the rules work for the practice, rather than getting the practice to conform to the rules.

Your job is to assist the physician in properly documenting and reporting the service, not to judge whether the work the physician performed was necessary.

Which Came First: the Service or the Code?

Coders and physicians sometimes move away from the concept that evaluation and management (E/M) codes were created to represent services, and instead try to make a service match the desired code. The physician should provide medically necessary services, fully document those services, and report the CPT® code that accurately represents his or her effort—in that order. Especially when considering E/M services, discuss with your physician what must be documented to report a certain service.

For example, physicians and coders sometimes fall into the trap of thinking that specialists should always bill high-level services. With that assumption, the physician will work backwards to include what the documentation should state to support the desired service level, and the coder will follow suit. To remedy this, meet with the physician to learn of the actual services he or she provides for different common chief complaints. Then, discuss with the physician ways he or she can document those services so that you can select an accurate E/M code level.

This is an opportunity to be open to possibilities. Talk to your physician about whether he or she is actually providing a time-based service. That is often the case when the physician can't get the note to meet the level he or she thinks is correct for the service.

Why Don't I Get Paid for That?

You may have heard that postoperative E/M services aren't billable, or that they are free services. What this conversation is often really about is the amount of reimbursement for the service, which is not the same as discussing a global package.

When a surgical package is developed, it includes the work and reimbursement for many services beyond the actual operation. As well, most payers consider many non-face-to-face services, such as telephone calls between clinic visits, as bundled with the most recent clinic visit.

When discussing this sort of thing with your physician, explain that the service was reimbursed as part of another code; it has already been paid. Reporting such services separately would mean reporting the same service twice, which would be wrong. Your physician will appreciate that you are looking out for his or her best interests.

Clarify Terms to Avoid Miscommunication

Physicians and coders may use the same terms to describe different things. For example, physicians usually don't make a distinction between the terms "consult" and "referral," while coders understand them to mean two different things. As well, some specialty physicians consider all new patient visits eligible for consultation service codes because they do not see patients without a referral. When discussing these terms from a coding perspective, clarify that you are discussing the requirements necessary for the CPT® Consultation Services codes.

Another common term that can mean one thing to a coder and another thing to a physician is "critical care." Physicians that care for patients on intensive care units (ICU) may consider all services they provide to be critical care services. They might also think the Critical Care Services CPT® codes are actually ICU services codes, and that those codes are used for all services provided on the unit. Take time to talk about these common terms and how they apply to coding guidelines versus the physician's practice to ensure everyone is speaking the same language.

Be Passionate About What You Do

I am mission-driven in my work with physicians. The smoother I can make the business of medicine run, the more time and effort the physician will have to treat patients, which ultimately means I can indirectly affect patient care. Figure out what motivates you as a coding professional and let your physicians know. This open communication is what builds healthy relationships in a practice, which is to everyone's benefit.

Terri Brame, MBA, CHC, CPC, CPC-H, CPC-I, CGSC, is the compliance education officer for the University of Arkansas for Medical Sciences. She is also the author of "E&M Coding Clear & Simple, Evaluation & Management Coding Worktext," published by F.A. Davis. Brame is a member of the Little Rock Central Arkansas local chapter and past local chapter president.

CMS Delays Two-midnight Rule for 90 Days

You have until Dec. 31, 2013 before the "two-midnight" rule is scrutinized by Centers for Medicare & Medicaid Services recovery audit contractors (RACs). CMS is giving providers a 90-day grace period to prepare for the new policy. Between Oct. 1 and Dec. 31, RACs cannot question the medical necessity of inpatient hospital stays simply because of their duration.

When the two-midnight rule goes into effect, inpatient stays lasting less than two midnights will be considered outpatient visits. According to a ModernHealthcare.com article (*Healthcare Business News*, Joe Carlson, "Auditors Will Delay Scrutiny of 'Two-midnight' Rule: CMS," Sept. 26, 2013), this change will affect reimbursement. Essentially, CMS will pay less and beneficiaries will pay more.

"The two-midnights rule says that hospital stays that last two days—defined as a stay that spans at least two midnights—are presumed to be legitimate uses of inpatient care and will not be subject to auditing, for the most part. Likewise, most stays that are shorter than that are presumed to have been appropriate for outpatient observation, a level of care for which Medicare pays less and subjects patients to much higher costs," Carlson writes.

For more information on the criteria for admission and medical review criteria for hospital inpatient services, see the 2014 Inpatient Prospective Payment System (IPPS) Final Rule Outreach (CMS 1599-F) at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY-2014-IPPS-Rule-Outreach.pdf.

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6/11 - 6/12	Dallas, TX
6/11—6/12	Oklahoma City, OK
6/25 - 6/26	Albany, NY
6/27 - 6/28	Indianapolis, IN
7/9 - 7/10	Las Vegas, NV
7/17 - 7/18	Baltimore, MD
7/22 - 7/23	Boise, ID
7/31 - 8/1	Cambridge, MA
8/6 - 8/7	Houston, TX
8/12 - 8/13	Atlantic City, NJ
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By Lanaya Sandberg, MBA, CPCO

10 Tips for the Early Career Enthusiast

Climb your way up the corporate ladder by positioning yourself as a leader.

The beginning of your career is an exciting time: You are ambitious, energetic, and the world is your oyster. You have a good idea of where you see yourself in the long term, but are unsure of how to get there. The following 10 tips will help you in clearing a path toward success.

1. Express your interests.

If you have not clearly expressed your interests and goals to your direct manager, do not assume he or she knows them. Share with your manager your goals and your game plan for achieving them. Let your colleagues and external business partners understand your goals, as well. The more people who know about your career interests and goals, the better off you are. These people may look to you when opportunities arise in the future.

2. Network, network, and network some more.

Although creating a LinkedIn® profile may seem like a mundane task, it's a great way to network. Your colleagues and business partners do not necessarily know all of your skill sets, work experiences, certifications, and education, so creating and maintaining a LinkedIn® profile serves as a valuable opportunity for others to get to know you better. You also can endorse the skill sets of others and make recommendations—which you may receive in return, thereby boosting your credibility. By keeping your Linkedin® profile up-to-date, you can easily create a resume when a new opportunity presents itself.

Attending AAPC local chapter meetings also is a great way to build relationships with colleagues and learn valuable information that will make you an asset to your employer. In this business, it's both what you know and who you know that gets you ahead.

3. Seek a supportive mentor.

A mentor can provide an objective assessment of your career development. A good mentor engages with the mentee and does not take the relationship lightly. He or she recognizes that a strong mentoring relationship requires dedication, time, support, and an open exchange of information. Think of a mentor as a synonym for a lifelong supporter.

Jean Garten, MHA, FACHE, principal at JG Consulting, has been both a mentee and a mentor. As a mentee, she has benefited from relationships with superiors, peers, and more experienced executives from various healthcare systems. While pursuing her master's degree in healthcare administration, she benefited from a mentor's wealth of knowledge about the healthcare industry. Garten said, "A successful person is one that surrounds themselves with wise advisors and actively listens and learns, which can make the difference between suc-

photo by iStockphoto/Alita

The more people who know about your career interests and goals, the better off you are.

cess and failure." Conversely, as a mentor, she has enjoyed sharing her experiences and insights with others. "To teach is to learn twice, and I have certainly found this to be true," Garten said.

4. Request constructive feedback.

In "Deliver Constructive Criticism the Thoughtful Way" (*AAPC Cutting Edge*, June 2013, pages 30-31), author **Brandi Tadlock CPC, CPC-P, CPMA, CPCO**, explains that it can be challenging to give and receive constructive feedback. For example, in the beginning of my career, I was very defensive, and I thought I knew everything. Then, during one of my annual reviews, a light bulb went off in my head. I realized that if I wasn't able to receive, process, and act on opportunities for improvement, I would never reach my professional goals. If you have the ability to apply constructive criticism, you bring value to the organization.

5. Write down your goals.

Write your professional goals down on a piece of paper and post them in a location you visit every day, such as on your refrigerator. On an annual basis, review your progress and reflect on the reasons that prohibited you from achieving any of your goals. Having a constant reminder of your goals and visualizing yourself achieving those goals will increase the likelihood of accomplishing them.

6. Learn your colleagues' personality types.

To achieve set desired outcomes, you may have to work with people whose opinions and perspectives differ from your own. This can be difficult, I know. The "Quick Guide to the 16 Personality Types in Organizations" (Linda V. Berens et al., 2011) provides a framework for how different personalities can work together successfully.

Berens recommends learning the personality types of those with whom you work to better accommodate their preferences. If you do not have the time to learn your co-workers' personality types through observation, just ask them. For example, you might ask what skills they bring to the team (e.g., one co-worker may be great at speaking, while another may excel at writing), what their work habits are (e.g., Are you a rabbit or a tortoise?), and what their preferences are when working as a team (e.g., Are you a leader or a follower?). Often you're thrown quickly into a team; taking time to get to know and understand each other will serve to create a more harmonious environment. And where there is harmony, there is success.

7. Improve your social intelligence.

In 2008, Daniel Goleman and Richard Boyatzis first coined the term social intelligence in *Harvard Business Review's* (HBR) "Social Intelligence and the Biology of Leadership." This concept recognizes that truly respected, effective leaders possess traditional technical skills, as well as the soft skills of compassion and concern for the wellbeing of others. Socially intelligent leaders benefit from greater performance yields than their counterparts who solely possess traditional skill sets. If you want to learn about social and emotional intelligence leadership skills, I recommend you read this article, as well as "What Makes a Leader" (Goleman, *HBR*, 1998).

8. Do your homework.

When you have identified your long-term, ideal job, research the credentials and experiences of someone who holds this position. For example, if you are interested in becoming a hospital administrator, research and study the work experiences, achievements, education, and certifications of someone who works as a hospital administrator. This can help you to develop a personal road map that will guide you to achieving your professional goals.

9. Set yourself apart.

Focus on differentiating yourself from your colleagues. Consider taking on projects that no one else is interested in, volunteering to participate in workgroups, or pursuing certifications relevant to your interested line of work. Remember: Just because no one has offered it to you doesn't necessarily mean the opportunity doesn't exist.

10. Be accountable.

In your professional life, you almost always have at least some involvement in how things are. In "How the Way We Talk Can Change the Way We Work," Robert Kegan and Lisa Laskow Lahey (2001) provide the following quote on page 38:

"Leaders who take an interest in fostering the language of personal responsibility are likely to find themselves in far more productive conversations with their employees and are likely to foster more productive conversations among their employees."

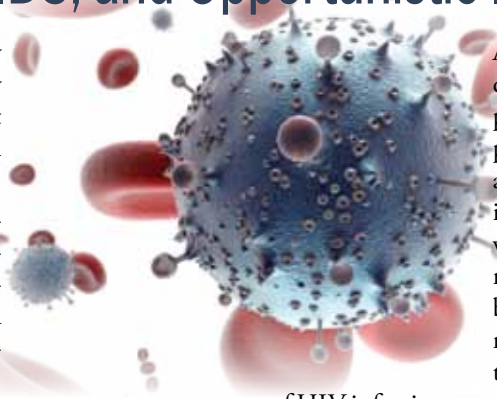
It isn't always about being right. More often, it's about being responsible for what you say and do.

Lanaya Sandberg, MBA, CPCO, is a network manager and responsible for the integration of healthcare mergers and acquisitions. She is a member of the Hartford, Conn., local chapter.

* The views and opinions expressed in this article are those of the author and do not reflect the official policy or position of any organization.

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Understanding HIV, AIDS, and Opportunistic Infections



Unlike some other viruses, the human body cannot rid itself of human immunodeficiency virus (HIV)—once you have HIV, you have it for life. HIV may or may not lead to acquired immunodeficiency syndrome (AIDS).

With proper medical care, HIV can be controlled. Treatment for HIV is often called antiretroviral therapy (ART). It can dramatically prolong the lives of people who are infected with HIV and lower the chances of them infecting others.

HIV affects specific cells of the immune system, called CD4 cells, or T cells. Over time, HIV can destroy so many of these cells that the body can't fight off infection and disease. When this happens, HIV infection leads to AIDS. The CDC categorization of HIV/AIDS is based on the lowest documented CD4 cell count and on previously diagnosed HIV-related conditions.

Clinical latency (i.e., inactivity or dormancy) is the period sometimes called asymptomatic HIV infection or chronic HIV infection. During this phase, HIV is still active, but reproduces at very low levels. Patients may present without any symptoms. Patients who are on ART may live with clinical latency for several decades. For people who are not on ART, this period can last up to a decade, but some may progress through this phase faster. Patients are still able to transmit HIV to others during this phase even if treated with ART. Toward the middle and end of this period, the viral load begins to rise and the CD4 cell count begins to drop. As this happens, patients' immune systems become too weak to protect them and they may begin to have symptoms of HIV infection.

AIDS is the stage of infection that occurs when the immune system is badly damaged and patients become vulnerable to opportunistic illnesses (OIs)—infections and infection-related cancers that feed off of weakened immune systems. Patients can also be diagnosed with AIDS if they develop one or more OIs, regardless of their CD4 count. The life expectancy for those who have a dangerous OI falls considerably compared to those who receive treatment.

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC, and a member of the Oil City, Pa., local chapter.

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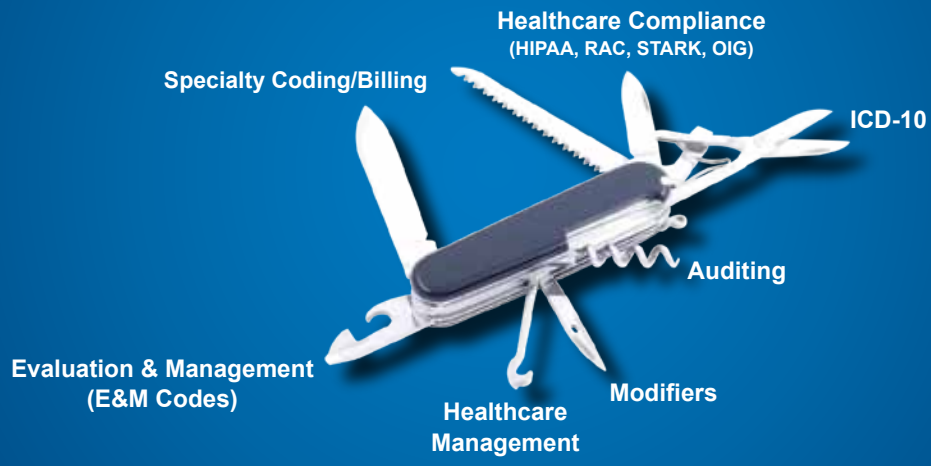

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Crystal Amjad, **CPC-A**
Crystal Ann Hopson, **CPC-A**
Crystal Chandler, **CPC-A**
Crystal Evonne Hales, **CPC-A**
Crystal Finley, **CPC-A**
Crystal Jacovetti, **CPC-A**
Crystal Leah Davis, **CPC-A**
Curtis Wilson, **CPC-A**
Cynde Meadows, **CPC-A**
Cynthia Barker, **CPC-A**
Cynthia Rowe, **CPC-A**
Cynthia Beardsworth, **CPC-A**
Cynthia Bookout, **CPC-A**
Cynthia Forney, **CPC-A**
Cynthia Ross, **CPC-A**
Dagmara Iglar, **CPC-A**
Daisy L Dublin, **CPC-A**
Daljeet Kaur Randhawa, **CPC-A**
Dan Taylor, **CPC-A**
Dana Brentson, **CPC-H-A**
Dana L Knockle, CPC-A, **CPC-H-A**
Dana Milquette, **CPC-A**
Dana Shine, **CPC-A**
Danhe' La'Nett Slinger, **CPC-A**
Daniel P McKeon, **CPC-A**
Danielle Dawn Torline, **CPC-A**
Danielle Dowdell, **CPC-A**
Danielle Elise Garee, **CPC-A**
Danielle Marie Langhauser, **CPC-A**
Danilo Cruz Aguirre, **CPC-A**
Dann Alissia Manuel Ang, **CPC-A**
Darcy Yadon, **CPC-A**
Darlene Murphy, **CPC-A**
Daurie Cumbie, **CPC-A**
Dave Durham, **CPC-A**
David Krupa Ranga Suppogu, **CPC-A**
David Miller, **CPC-A**

Newly Credentialed Members

David Sass, **CPC-H-A**
Dawn Corbisier, **CPC-A**
Dawn Deliyanides, **CPC-A**
Dawn Doerr, **CPC-A**
Dawn Englebert, **CPC-A**
Dawn Tankersley, **CPC-A**
Dawn Taylor, **CPC-A**
Dayana M Valdes, **CPC-A**
Debbie Erickson, **CPC-A**
Debbie Ruth Thomason, **CPC-A**
Deborah Ann Conrady, **CPC-A**
Deborah Dwelly, **CPC-H-A**
Deborah Wallace, **CPC-A**
Debra Madden, **CPC-A**
Debra Mancl, **CPC-A**
Debra Timmins, **CPC-A**
Debra Weichman, **CPC-A**
Deepa Palani, **CPC-A**
Deepak Kapoor, **CPC-A**
Deidre Johnson, **CPC-A**
Deirdre Espinoza, **CPC-H-A**
Deliah Murphy, **CPC-A**
Denise Balentine-Womack, **CPC-A**
Denise Michelbook, **CPC-A**
Dennis G Martineau, **CPC-A**
Deree Murray, **CPC-A**
Desiree Nicole Ford, CPC-A, **CPC-H-A**
Devaraju Essampally, **CPC-A**
Devi Krishnamoorthy, **CPC-A**
Devona Wozniak, **CPC-A**
Dhanalakshmi Srinivasan, **CPC-A**
Dheenadayalan Balaraman, **CPC-A**
Diana Karen Womack, **CPC-A**
Diane Brown, **CPC-A**
Diane Leger, **CPC-H-A**
Diane Rains-Brandon, **CPC-A**
Dianne Deeney, **CPC-A**
Dianne Morton, **CPC-A**
Dina Renee Vega, **CPC-A**
Dinesh Swamikan, **CPC-A**
Disha Chavan, **CPC-A**
Divya Balakrishnan, **CPC-A**
Divya Gupta, **CPC-A**
Djana Arnautovic, **CPC-A**
Donald Ross, **CPC-A**
Donna Ann Simons, **CPC-A**
Donna Jane Phillips, **CPC-A**
Donna Kever, **CPC-A**
Donna M. O'Donnell, **CPC-A**
Donna Rooney, **CPC-A**
Donnis Herndon, **CPC-A**
Doreen DiPietro, **CPC-A**
Dori Steckley, **CPC-A**
Doris Higgins, **CPC-A**
Doris Ivette Menendez, **CPC-A**
Dorothy Jones, **CPC-A**
Douglas Alan Thomas, **CPC-A**
Dustin Guthrie, **CPC-A**
Dyan Joyce Gantangco Cabatbat, **CPC-A**
Edris Thorsted, **CPC-A**
Edward Russel Valenzuela Apostol, **CPC-A**
Efren Benedict Plandes, **CPC-A**
Eileen Perry, **CPC-A**
Eileen Kashulines, **CPC-A**
Elaine Mcavoy, **CPC-A**
Elaine Syrkin, **CPC-A**
Elesha Smith, **CPC-A**
Elizabeth Elder, **CPC-H-A**
Elizabeth Monroe, **CPC-A**
Elizabeth Norfleet, **CPC-A**
Elizabeth Wagner, **CPC-A**
Elizabeth Wright, **CPC-A**
Ellen Richardson, **CPC-A**
Elyse Myers, **CPC-A**
Emilia Saintvil, **CPC-A**
Eric G Bond, **CPC-A**
Eric Greco, **CPC-A**
Eric Jaenichen, **CPC-A**
Erica Silva, **CPC-A**
Erica Tripp, **CPC-A**
Ericka Richardson, **CPC-A**
Erika Jean Oh Azarcon, **CPC-A**
Erin Neu, **CPC-A**
Erin Noble, **CPC-A**
Erin West, **CPC-A**
Ernest Clark, **CPC-A**
Esther Borlovan, **CPC-A**
Ethel Joy Abcede Javier, **CPC-A**
Eugina Arokianirmala Abel, **CPC-A**
Evelyn Duncan, **CPC-A**
Ever Queen Villa Leono, **CPC-A**
Fathima Amiruddin, CPC-A, **CPC-H-A**
Faye Rastegar, **CPC-A**
Fern Graczik, **CPC-A**
Flora M, **CPC-A**
Florinda Colucci, **CPC-A**
Frances Bernal, **CPC-A**
Frances Paris, **CPC-A**
Francisca Chavez, **CPC-A**
Francisco Corcelles Kirong, **CPC-A**
Frank Edward Longoria, **CPC-A**
Frederick Angeles Latonio, **CPC-A**
Gajalakshmi Krishnamoorthy, **CPC-A**
Gajendra Singh, **CPC-A**
Gale Hartley, **CPC-A**
Gaurav Byas, **CPC-A**
Gay Goodfriend, **CPC-A**
Genevieve Seghini, **CPC-A**
Genia Graybill, **CPC-A**
George Esguerra, **CPC-A**
Gina Holley, **CPC-A**
Gina Ponce De Leon, **CPC-A**
Gina R Sullivan, **CPC-A**
Glenn Wood, **CPC-A**
Gopinath Jayaraman, **CPC-A**
Gouthami Kasanagottu, **CPC-A**
Grace M Rymers, **CPC-A**
Gregory Cutrera, **CPC-H-A**
Gretta Willig, **CPC-H-A**
Grisel Perdomo, **CPC-A**
Gunjan Santiago, **CPC-A**
Gwen Gibson, **CPC-A**
Gwen Hucker, **CPC-A**
Haidee Salonga Wage, **CPC-A**
Hailey Trapier, **CPC-A**
Haley Evans, **CPC-A**
Haley Loudenslager, **CPC-A**
Hannah Triplett, **CPC-A**
Haralee Weintraub, **CPC-A**
Hari Shankar Singh, **CPC-A**
Harris Rile Camacho, **CPC-A**
Harsha Nimkar, **CPC-H-A**
Harvinder Kaur Bhamrah, **CPC-A**
Hazel Yuhas, **CPC-A**
Hazmin Mendez Almilla, **CPC-A**
Heather Bieberich, **CPC-A**
Heather Carol Shimp, **CPC-A**
Heather Ham, **CPC-A**
Heather Marie Brown, **CPC-A**
Heather N Damask, **CPC-A**
Heide Fajutnao De Los Santos, **CPC-A**
Heidi Smith, **CPC-A**
Helen C Strasko, **CPC-A**
Helga Russell, **CPC-A**
Herve Mathelier, **CPC-A**
Hillary Morris, **CPC-A**
Holly Allen, **CPC-A**
Holly Renee Allen, **CPC-A**
Hope Millovich, **CPC-A**
Ian Mieles, **CPC-A**
Ice Cream Garcia Angeles, **CPC-A**
Imee Noriza Sta Maria Ramirez, **CPC-A**
Ingrid Soriano, **CPC-A**
Irina McNeace, **CPC-A**
Ishwariya Jayaraj, **CPC-A**
Iza Falco, **CPC-A**
Jacqueline DeLosSantos, **CPC-A**
Jacqueline Hydock, **CPC-A**
Jacqueline Nicole Rhodes, **CPC-A**
Jacquelyn Ann Drissel, **CPC-A**
Jagadish Kumar Chakka, **CPC-A**
Jaime M Roussard, **CPC-A**
Jaimini Patel, **CPC-A**
Ja'mella Renee Martinez, **CPC-A**
Jamie Butler, **CPC-A**
Jamie Mccarty, **CPC-A**
Jan Arvie Pascual David, **CPC-A**
Jan Johnston, **CPC-A**
Jan Lewis, **CPC-A**
Jana Piper, **CPC-A**
Jane Hegmann, **CPC-A**
Jane Rogers, **CPC-A**
Janeen Pier Johannsen, **CPC-A**
Janell Brannon, **CPC-A**
Janelly Alvarez, **CPC-A**
Janet Matko, **CPC-A**
Janet Sanders, **CPC-A**
Janice Bohn, **CPC-A**
Janice Carter, **CPC-A**
Janice Denette Foreman, **CPC-A**
Janice Mascelli, **CPC-A**
Janice Spies, **CPC-A**
Jan-Michael Rondilla Razote, **CPC-A**
Jannica Atencio, **CPC-A**
Jasmine Bertsch, **CPC-A**
Jason Dozier Hearl, **CPC-A**
Jason San Juan Catbagan, **CPC-A**
Javier David Leon, **CPC-A**
Jay Michael Burkard, **CPC-A**
Jayasubha Jayapalu, **CPC-A**
Jayson Bautista, **CPC-A**
Jayson Malabuyoc, **CPC-A**
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Jeanne Adomatis, **CPC-A**
Jeannine Reed-Heil, **CPC-A**
Jeffrey A Hildebrand, **CPC-A**
Jeffrey Garcia Serrano, **CPC-A**
Jegannathan Arumugam, **CPC-A**
Jellie Vasquez, **CPC-A**
Jeneen King, **CPC-A**
Jenifer Green, **CPC-A**
Jenita Arulraj, **CPC-A**
Jenni Doan, **CPC-A**
Jennifer Bataille, **CPC-A**
Jennifer Dobbins, **CPC-A**
Jennifer Elyse Tokle, **CPC-A**
Jennifer Fairman, **CPC-A**
Jennifer Joy Howard, **CPC-A**
Jennifer L McMahon, **CPC-A**
Jennifer Legaspi Tiongson, **CPC-A**
Jennifer Louise Phillips, **CPC-A**
Jennifer Lynn Campbell, **CPC-A**
Jennifer Lynn Kucharski, **CPC-A**
Jennifer Lynn Reed, **CPC-A**
Jennifer Lynn Ryder, **CPC-A**
Jennifer Norris, **CPC-A**
Jennifer Norton, CPC-A, **CPC-H-A**
Jennifer Pagan, **CPC-A**
Jennifer Reeves, **CPC-A**
Jennifer Trout, **CPC-A**
Jennifer Works, **CPC-A**
Jenny Heath, **CPC-A**
Jenny L. Marks, **CPC-A**
Jerri Lynn Menz, **CPC-A**
Jerthem Bernal Cercado, **CPC-A**
Jessica Bonner, **CPC-H-A**
Jessica Berdiel, **CPC-A**
Jessica Berrios, **CPC-A**
Jessica DeLillo, **CPC-A**
Jessica Eve Wharton, **CPC-A**
Jessica L Ballentine, **CPC-A**
Jessica L Zanotti, **CPC-A**
Jessica Lenora Conley, **CPC-A**
Jessica Martin, **CPC-A**
Jessica Parker, **CPC-A**
Jessica Pickel, **CPC-A**
Jessica Rea Castillo, **CPC-A**
Jessica Vaughn, **CPC-A**
Jessica Waechter, **CPC-H-A**
Jessica Williams, **CPC-A**
Jessy Jessy Varghese, **CPC-A**
Jesus Miguel Rivera Buenaventura, **CPC-A**
Jesus Teijeiro, **CPC-A**
Jibin Thomas, **CPC-A**
Jill Ray, **CPC-A**
Jitender Kumar, **CPC-A**
Jo Ellen Fields, **CPC-A**
Joanna Milewski, **CPC-A**
Joanne Baisden, **CPC-A**
Jocelyn Mercer, **CPC-A**
Jodi Phillips, **CPC-A**
Jody Richardson, **CPC-A**
Joely Guillotte, **CPC-A**
Joey Felonine Namayan, **CPC-A**
John Feazelle, **CPC-A**
John Moss, **CPC-A**
John Sunderland, **CPC-A**
Johnna Westmoreland, **CPC-A**
Jonathan A Mercado, **CPC-A**
Joquetta Bussie, **CPC-A**
Jorri Tremain, **CPC-H-A**
Joseanne Peralta De Jesus, **CPC-A**
Josefina Soriano, **CPC-A**
Joseph Baltazar, **CPC-A**
Joseph J Biernat, **CPC-A**
Joseph Samet, **CPC-A**
Joseph Teakell, **CPC-A**
Joy Anne Cabiles Lacanilao, **CPC-A**
Joy DeLong, **CPC-A**
Joyce Krzynski, **CPC-A**
Judith Ann Barbosa, **CPC-A**
Judith Ann Hunt, **CPC-A**
Judith Ann Roberts, **CPC-A**
Judy Breau, **CPC-A**
Judy K Muench, **CPC-A**
Judy Methwani, **CPC-A**
Judy S Wright, **CPC-A**
Julia Engle, **CPC-A**
Julia Mohler, **CPC-A**
Julian Coram, **CPC-A**
Julie Annette Swanson, **CPC-A**
Julie Beckstead, **CPC-A**
Julie Brown, **CPC-A**
Julie Hines, **CPC-A**
Julie Karas, **CPC-A**
Julie Newman, **CPC-A**
Julie Scherr Marable, **CPC-A**
Julie Urosevich, **CPC-A**
Jung Hwang, **CPC-H-A**
Juran Lorenzo Pless, **CPC-A**
Justin Wardell, **CPC-A**
Justin Kyle, **CPC-A**
Jyoti Patil, **CPC-A**
Kacie Miller, **CPC-A**
Kailie Winland, **CPC-A**
Kaitlyn Davis, **CPC-A**
Kalimuthu Ramasamy, **CPC-A**
Kara Cochran, **CPC-A**
Kara O'Bannon, **CPC-A**
Kara Ramboz, **CPC-A**
Karen DeLong, **CPC-A**
Karen Elwell, **CPC-A**
Karen Garcia, **CPC-A**
Karen Haws, **CPC-A**
Karen Hester, **CPC-A**
Karen Joy Abuan Vidar, **CPC-A**
Karen Magda, **CPC-A**
Karen Parker, **CPC-A**
Karen S. Buck, **CPC-A**
Karen Vandiver, **CPC-A**
Karl Custodio, **CPC-A**
Karla Mancuso, **CPC-A**
Kartigui Perumal, **CPC-A**
Kate Barbee, **CPC-A**
Katelyn Elizabeth Marie Raynor, **CPC-A**
Katharine MacAlister, **CPC-A**
Katherine Davis, **CPC-A**
Katherine Earley, **CPC-A**
Katherine Freeburn, **CPC-A**
Katherine Marie Zernow-Wells, **CPC-A**
Katherine Przystup, **CPC-A**
Kathija Beevi Abdul Hameed, **CPC-A**
Kathleen A Galioto, **CPC-A**
Kathleen A Roddy, **CPC-A**
Kathleen D Koser, **CPC-A**
Kathleen Grinberg-Funes, **CPC-A**
Kathleen McCourt, **CPC-A**
Kathleen Mcnall, **CPC-A**
Kathleen Moore, **CPC-A**
Kathrina Denise Dickmeyer, **CPC-A**
Kathryn Dee Footit, **CPC-A**
Kathryn Hoefer, **CPC-A**
Kathryn Nardi, **CPC-A**
Kathy Bailey, **CPC-A**
Kathy DeArmas, **CPC-A**
Kathy Gaspari, **CPC-A**
Kathy Johnson, **CPC-A**
Kathy Lynne Schmitz, CPC-A, **CPC-H-A**
Kathy Renee Dahms, **CPC-A**
Katie Elizabeth Mahajan, **CPC-A**
Katie Ferriss, **CPC-A**
Katrina Fajardo Satonero, **CPC-A**
Katrina Taylor, **CPC-A**
Katsue Whatley, **CPC-A**
Kattie Stephens, **CPC-A**
Kaushikrajan Manickavasagam, **CPC-A**
Kavita Sharma, **CPC-A**
Kayla Green, **CPC-A**
Kayla Law, **CPC-A**
Kayla Vogel, **CPC-A**
Kelley Duffy, **CPC-A**
Kelli Bourgeois, **CPC-A**
Kelli Lorenz, **CPC-A**
Kelli Lynn Pastyrnak, **CPC-A**
Kelli Turner, **CPC-A**
Kelly Boucher, **CPC-A**
Kelly McCrary, **CPC-A**
Kelly N Armstrong, **CPC-A**
Kelsea Shuldes, **CPC-A**
Kelsey McHenry, **CPC-A**
Kelsey Raschelle Gerard, **CPC-H-A**
Kelti Reid, **CPC-A**
Kenyetta L Bigham, **CPC-A**
Kerry Sautter, **CPC-A**
Keslie Meyers, **CPC-A**
Khylee Jo Lutz, **CPC-A**
Khyrsis Gonzalez Perez, **CPC-A**
Kierre Scott, **CPC-A**
Kim Blackburn Tobin, **CPC-A**
Kim Boyd, **CPC-A**

Kim Kaneshiro, **CPC-A**
Kim Marie Kielbasa, **CPC-A**
Kim Strickland, **CPC-A**
Kimberly Anderson, **CPC-A**
Kimberly Ann Lawson, **CPC-A**
Kimberly D Holmes, **CPC-A**
Kimberly McCardle, **CPC-H-A**
Kimberly R Leonard, **CPC-A**
Kimberly Rowland, **CPC-A**
Kiruthika Devaraj, **CPC-A**
Komal Vishal Majmudar, **CPC-A**
Kori Michelle Sheff, CPC-A, **CPC-H-A**
Kori Michelle Sheff, **CPC-A**
Kris Dalton, **CPC-A**
Krishna Chaitanya Madasu, **CPC-A**
Krishnaraj Manavalan, **CPC-A**
Krista Wickline, **CPC-A**
Kristen Bitzan, **CPC-H-A**
Kristen Jackson, **CPC-A**
Kristin Ann Heiken , CPC-A, **CPC-H-A**
Kristin Fearn, **CPC-A**
Kristina Knox Yancey, **CPC-A**
Kristle Rose Salonga Vendivil, **CPC-A**
Kristopher Howard Ritchie, CPC-A, **CPC-H-A**
Krystal Jostock, **CPC-A**
Krystle Wilkes, **CPC-A**
Kundankumar Thakur, **CPC-A**
Kyra Crutchfield, **CPC-A**
Lacy Hedges, **CPC-A**
Lalique Petersen, **CPC-A**
Lalita Anjaneyulu Bokka, **CPC-A**
Lanka Sravanthi, **CPC-A**
Larena E Grieshaber, **CPC-A**
LaShandra Cloud, **CPC-A**
Laura Elizabeth Hocker, CPC-A, **CPC-H-A**
Laura Gonzales, **CPC-A**
Laura Mackey, **CPC-A**
Laura Pendergrass, **CPC-A**
Laura Quitugua, **CPC-A**
Laura Sabath, **CPC-A**
Laura Styler, **CPC-A**
Laurel Savage, **CPC-A**
Lauren D'Amato, **CPC-A**
Lauren Averett, **CPC-H-A**
Lauren Diana Jozwiak, **CPC-A**
Lauren E Bova, **CPC-A**
Lauren Theriault, **CPC-A**
Laurie Hoffman, **CPC-H-A**
Lavetta J Pope, **CPC-A**
Leah Jeffers, **CPC-A**
Leah Penkalski, **CPC-A**
Leah Pruitt, **CPC-A**
Lee Dietz, **CPC-A**
Lee Walker, **CPC-A**
Lei Ann Bedwell, **CPC-A**
Lelonie Lenise Jackson, **CPC-A**
Lenka Hall, **CPC-A**
Leona Kuhnke, **CPC-A**
Lesa Schafer, **CPC-A**
Leslee G Kronberg , CPC-A, **CPC-H-A**
Lesley McAfee, **CPC-A**
Lesley Redmon, **CPC-A**
Leticia Murillo, **CPC-A**
Lia M McCurdy, **CPC-A**
Liberty Caguiat Valerio, **CPC-A**
Linda Burnside, **CPC-H-A**
Linda Claire Casperson, **CPC-A**
Linda Conway, **CPC-A**
Linda Hammontree, **CPC-A**
Linda Mayberry, **CPC-A**
Linda Medcraft, **CPC-A**
Linda Russell, **CPC-A**
Linda Stricklin, **CPC-H-A**
Linda T Thomas, **CPC-A**
Linda Thomas, **CPC-A**
Lindsay Hillman, **CPC-A**
Lindsay Suarez, **CPC-A**
Lindy Benoit, **CPC-H-A**
Lisa Becker, **CPC-A**
Lisa Cathey, **CPC-A**
Lisa Demarco, **CPC-A**
Lisa Gayle Griffin, **CPC-A**
Lisa Harding, **CPC-A**
Lisa J Becherer, **CPC-A**
Lisa Kenworthy, **CPC-A**
Lisa M Hurley, **CPC-A**
Lisa Schechtman, **CPC-A**
Lisa Smith, **CPC-A**
Lisa Sumner, **CPC-A**
Lisa Therese Erdman, **CPC-A**
Liza Vazquez, **CPC-A**
Loida Perez, **CPC-A**
Lola Lane, **CPC-A**
Lorena Montes, **CPC-A**
Loretta Razmpour, **CPC-A**
Lori Buskohl, **CPC-A**
Lori Ferreira, **CPC-A**
Lori Massie, **CPC-A**
Lori McArthur, **CPC-A**
Lori Stauffer, **CPC-A**
Lorraine Kae Anderson, **CPC-A**
Lorrie Marena Mixon, **CPC-A**
Louis Roybal, **CPC-A**
Louise Nalica, **CPC-A**
Louise Savoye, **CPC-H-A**
Lourdes G Acciani, **CPC-A**
Lucreia Bennett, **CPC-A**
Lucy Lee, **CPC-A**
Lynda E Cyr, **CPC-A**
Lyndsay Majewski, **CPC-A**
M.Babu, **CPC-A**
Ma Katrina Antonio Mapalo, **CPC-A**
Machut Zimik, **CPC-A**
Maddie Noseworthy, **CPC-A**
Mageshwari Dearajan, **CPC-A**
Malisa Jackson, **CPC-A**
Manchikatla Ramya, **CPC-A**
Mandy J. Powers, **CPC-A**
Manish Kumar Kushwaha, **CPC-A**
Manju Manickam, **CPC-A**
Manjusha Udayagiri, **CPC-A**
Manuel Rebong Sancon, **CPC-A**
Marc Lawrence Szczepanik, **CPC-A**
Marcy Gavaghan, **CPC-A**
Margaret Rae Heil, **CPC-A**
Margaret Stevenson, **CPC-A**
Marguerite Anne LaBelle, **CPC-A**
Marguerite Sarel, **CPC-A**
Maria Angelica Leobrera Roqueza, **CPC-A**
Maria Burns, **CPC-A**
Maria Catherine Sarasa Mangubat, **CPC-A**
Maria Chappell, **CPC-A**
Maria Christina Corral, **CPC-A**
Maria Donnabelle Manalo Tongol, **CPC-A**
Maria Erika Tan Hama, **CPC-A**
Maria Karen Canent Manuel, **CPC-A**
Maria Monica Baraan Acosta, **CPC-A**
Maria Olteanu, **CPC-A**
Maria Schoenfeldt, **CPC-A**
Maria Smith, **CPC-H-A**
Marianne Restel, **CPC-A**
Maribel Rodriguez, **CPC-H-A**
Maribel Morallo Manalastas, **CPC-A**
Marie Johnson, **CPC-A**
Marie L Derby, **CPC-A**
Marie Schipani, **CPC-A**
Marilyn Bushno, **CPC-A**
Marina Ammirato , CPC-A, **CPC-H-A**
Marjoris Betancourt Reyes, **CPC-A**
Mark Dumler, **CPC-A**
Mark Jade Battung Pintor, **CPC-A**
Marlon Butler, **CPC-H-A**
Marta T Acosta, **CPC-A**
Marvin Price, **CPC-A**
Mary Anne Moore, **CPC-A**
Mary C King, **CPC-A**
Mary F Wilson, **CPC-A**
Mary G Emerling, **CPC-A**
Mary Garcia, **CPC-A**
Mary Ruane, **CPC-A**
Mary Scott, **CPC-A**
Mary Typhair, **CPC-A**
Mason Ibarra, **CPC-A**
Mattea Brancato, **CPC-A**
Maxyz Kunkle, **CPC-A**
Mayrah Linette Loya, **CPC-A**
Mayuri Kokkula, **CPC-A**
Meenakshi Munikannan, **CPC-A**
MegalaPriya Duraipandiyan, **CPC-A**
Megan Elizabeth Grammer, **CPC-A**
Megan Elizabeth Varga, **CPC-A**
Megan Hilleary, **CPC-A**
Megha Chandrakant Kadam, **CPC-A**
Meghann Mowbray, **CPC-A**
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Melanie Mataac Vidad, **CPC-A**
Melanie Province, **CPC-A**
Melinda Green, **CPC-A**
Melinda Newitt, **CPC-A**
Melinda Williams, **CPC-A**
Melissa Ann Jones, **CPC-A**
Melissa Danielle DeLuca, **CPC-A**
Melissa Ledezma, **CPC-A**
Melissa May Watts, **CPC-A**
Melissa McDermott, **CPC-A**
Melissa Rennie, **CPC-A**
Melissa Staniszewski, **CPC-A**
Melissa Story, **CPC-A**
Melissa Sue Havens, CPC-A, **CPC-H-A**
Melissa Woessner, **CPC-A**
Melissa Wyles, **CPC-A**
Melissah Nicole Green, **CPC-A**
Melody Atwood, **CPC-A**
Melony Session, **CPC-A**
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Michele Buzzard, **CPC-A**
Michele Zweydorff, **CPC-A**
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Michelle Jeglinski, **CPC-A**
Michelle Lynn Bautista, **CPC-A**
Michelle Mackey, **CPC-A**
Michelle Payzant, **CPC-H-A**
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Milagra Wain, **CPC-A**
Mildred Buggs, **CPC-A**
Millie Robles, **CPC-A**
Miranda Blackburn, **CPC-A**
Miriam O'Connor, **CPC-A**
Miriam Walters, **CPC-A**
Mohamed Jasheer, **CPC-A**
Mohammad Talat Zaheer, **CPC-A**
Mohammed Imtiyaz, **CPC-A**
Mohan Nagarajan, **CPC-A**
Mohit Gupta, **CPC-A**
Molly Garcia, **CPC-A**
Momi Santiago, **CPC-A**
Monica Rodriguez, **CPC-A**
Monica Smeltzer, **CPC-A**
Monroe Woodham IV, **CPC-A**
Montserrat Gower, **CPC-A**
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Muthumanikandan Ganesan, **CPC-A**
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Natasha Webb, **CPC-A**
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Nathaniel Sampath, **CPC-A**
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Neelamegam Rasu, **CPC-A**
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Nicki Pirtle, **CPC-A**
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Nicole Jensen, **CPC-A**
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Nina McClintock, **CPC-A**
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Pamela Heppner, **CPC-A**
Pamela Rena James, **CPC-A**
Pamela Stack, **CPC-A**
Pamela Steelman, **CPC-A**
Pamela Stoffel, **CPC-A**
Pamela Straughan, **CPC-A**
Pamela Stumpf, **CPC-A**
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Parupally Sailaja, **CPC-A**
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Patricia Morgerson, **CPC-A**
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Prateek Khanna, **CPC-A**
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Priyanka Sharma, **CPC-A**
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Shawn Michael Rudy, **CPC-A**
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Sherrie Page Calvert, **CPC-A**
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Staci Burger, **CPC-A**
Stacy Taylor, **CPC-A**
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Stephanie Ann Peloso, **CPC-A**
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Tara O'Daniel, **CPC-A**
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Teresa Cook, **CPC-A**
Teresa Lambert, **CPC-A**
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Teresa Schorr, **CPC-A**
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Terri Henthorn, **CPC-A**
Terri Lee, **CPC-A**
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Trudy Bettinger, **CPC-A**
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Valeria Hanson, **CPC-H-A**
Valerie Bass, **CPC-A**
Valerie Gomogda, **CPC-A**
Valerie Miller, **CPC-A**
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Veeramani Kannusamy, **CPC-A**
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Vishvadeep Bhardwaj, **CPC-A**
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Yvonne Conde Novio, **CPC-A**
Zaccheus Davis, **CPC-A**
Zachary Martinson, **CPC-A**
Zameer Khan Mohammad, **CPC-A**
Zarielle Zamora Espanol, **CPC-A**
Ziennia Dean Astilla, **CPC-A**

Specialties

Aarti Shri Ramraj Yadav, CPC-A, **CIRCC**
Adam Christopher Jung, CPC, **CPMA**
Adebisi Patricia Adeniji-Nelson, CPC-A, **CPMA**
Alan Moon, CPC, **CPPM**
Alisa Marie Hartley, CPC, **CIRCC**
Amber West, CPC-H, **CEDC**
Amy C Pritchett, CPC, **CASCC**
Amy E Mervin, CPC, **CEDC**
Amy Mccracken, CPC, **CEMC**
Amy Phillips, CPC, **CSFAC**
Angela Jackson, CPC, **CEDC**
Angela Martinez, CPC, **CEMC**
Angela Robinson, **COSC**
Aniladiv Acuna, CPC-A, **CPMA**
Anita M Bennett, CPC, **CFPC**
Anna Fye, CPC-H-A, **CIRCC**
April Harris, CPC, **CPEDC**
April Horton, **CASCC**
April M Ramos, CPC, CPMA, **CHONC**
Ashley Breeden, **CPCO**
Ashley Hack, CPC, **CPPM**
Barbara J Earps, CPC, **CHONC**
Becky Hannah, CPC, **CEMC**
Beth Ann Niewiadomski, CPC, **CPPM**
Beth Yaskin, **CPCO**
Betty Prescott-Paschal, CPC, **CEMC**
Brenda J Ozimek, CPC, CPC-H, **CHONC**
Brenda Williams-Young, CPC, CPC-I, **CEMC**
Candace Fabris, CPC, **CANPC**
Carla Brown McCown, CPC, **CPCO**
Carla J Townsend, CPC, **CPPM**
Carlos R Rios, CPC, **CEMC**
Carol Bingham, CPC-A, **CPPM**
Carole VanSant, **CIRCC**
Carolyn Briscoe, CPC, **CPMA**
Carrie A Rodriguez, CPC, **CPCO**, CPMA
Carrie Hatfield, CPC, **CEMC**, COSC
Carrie Lapka, **CPPM**
Charles Floyd, **CPCO**
Chelle L Johnson, CPC, **CPPM**, CEMC
Cheol Lee, CPC-A, **CPB**
Cheryl Pascale, **CANPC**
Christina J McLain, CPC, **CPMA**
Christine Abella, **CPMA**
Cindi Marantz Kline, CPC, **CPMA**
Clare Wallin, CPC, **CPPM**
Coleen Byrne, **CUC**
Colleen Williams, CPC, **CANPC**
Connie Whitesides, **CPCO**
Conrad Sinsay, CPC, **CEMC**
Cynthia Baker, CPC, **COSC**
Cynthia Denniston, **CPMA**
Cynthia M Allen, CPC, **CIRCC**
Cynthia Poth, CPC, **CPMA**
Cynthia Volsky, CPC, **CPMA**
Daisy Frontela, CPC, **CPMA**
Dana Lynn Cline, CPC, **CPB**
Danielle Marie Bender, CPC, **CPMA**
Dawn Beemer, CPC, **CPMA**, CPC-I
Dawn Sorensen, CPC, **CPPM**
Dean James Leanch, CPC, **CPB**
Debbie Taube, CPC, CPC-H, **CPMA**
Deborah K McConnell, CPC, CGIC, **COSC**
Deborah L Adler, CPC, **COSC**
Deborah M Pounder, RN, BSN, CPC, **CPMA**
Debra Brannon, CPC, **CPMA**
Debra Graham, CPC, **CEMC**
Debra Northrup, CPC, **CPMA**
Dee Ann Moody, CPC, **CASCC**
Delores Kim Frieben, CPC, **CPPM**
Denise Herbert, CPC, **CPPM**
Denise King, **CANPC**
Denise Lyke, CPC, **CPMA**
Denise Snoozy, **CENTC**
Diana Florence Mignogna, CPC, **CANPC**
Diana Renee Blankinship, CPC, **CPMA**, CEMC
Diane Chiodo, CPC, **CGIC**
Donna Keithley, CPC, **CEMC**, **CPCD**
Donna Lynne Gilbert, CPC, **CPMA**, CPC-I
Donnia Tritle, **COSC**
Doreen Carlson, **CPPM**
Elaine M Barry, CPC, CPC-H, **CEDC**
Elizabeth Betsy Gundersen, CPC, **CPMA**
Elizabeth Zavala, CPC, **CPEDC**
Emily Neumann, **CANPC**
Emily Augenti, **CHONC**
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A&P Quiz (from page 37)

The correct answer is B.

OI stands for "opportunistic infection." Opportunistic infections take advantage of a weakened immune system.

The Centers for Disease Control and Prevention (CDC) developed a list of more than 20 OIs that are considered AIDS-defining conditions:

- Candidiasis of bronchi, trachea, esophagus, or lungs
- Invasive cervical cancer
- Coccidioidomycosis
- Cryptococcosis
- Cryptosporidiosis, chronic intestinal (greater than 1 month's duration)
- Cytomegalovirus disease (particularly CMV retinitis)
- Encephalopathy, HIV-related
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis
- Isosporiasis, chronic intestinal (greater than 1 month's duration)
- Kaposi's sarcoma
- Lymphoma, multiple forms
- Mycobacterium avium complex
- Tuberculosis
- Pneumocystis carinii pneumonia
- Pneumonia, recurrent
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

Amanda T. Wirta, CPC

Coding Specialist at Grand Itasca Clinic & Hospital, Grand Rapids, Minn.

Tell us a little bit about your career—how you got into coding, what you've done during your coding career, what you're doing now, etc.

I am a coder by day, violinist by night.

I went to school for music and became burnt out. I met my husband and moved to a smaller town. I found a job working in medical records at the local hospital and clinic, but I wanted to do more than just file charts. For two years, I took online classes and worked full time, all while traveling to play in a symphony 75 miles away a few times a month. It was hard to stay motivated, but I knew it would pay off. In 2008, I received a certificate in Medical Coding and Insurance with a 4.0 grade point average. Two years passed before I was finally offered a coding position where I worked.

I've been a coder for over three years now, and I love it. The key to my success was getting my foot in the door by working in medical records while waiting for a better position. During that time, the coding department let me sit in on webinars to help me keep up with my coding education. I'm mainly a clinic coder, but I've been learning inpatient and day surgery procedures, too. I look forward to learning more about these areas, as well as ICD-10. I'm not, however, in love with our electronic health record system. They all seem to have some glitches.

I still play in two local orchestras, which seems to balance out my life perfectly.

What is your involvement with your local AAPC chapter?

When I started out, I was secretary/treasurer for a year. The closest chapter is 45 minutes away, in Hibbing, Minn., and I haven't been involved since the birth of my son in 2011. I look forward to getting back to it soon.

What AAPC benefits do you like the most?

I love looking at the online forums. I look at them weekly to help others and also to learn new things.

What has been your biggest challenge as a coder?

Because I'm shy, my biggest challenge has been interacting with providers. They all have different personalities—some are nice, and some are really arrogant. I remind myself that I'm smart, too, and they're not necessarily looking at things from a coder's point of view. It can take some time to get through to them, but it's usually worth it.

How is your organization preparing for ICD-10?

We have been refreshing our anatomy and pathophysiology training and taking as many webinars as possible. We're a great team and are always learning from each other.

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

It would be great to be a violinist full time, but it's just not financially possible. Orchestras throughout the world are struggling. People forget to support their local arts community. They don't realize how important it is until it's gone. If money was plentiful, I also would love to open up an animal shelter in our area and a program to spay and neuter pets—please spay or neuter your pets!

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

I love spending time with my husband, Scott, of seven years and our 2-year-old son, Quinn. We love to bike, camp, and explore just about anything and everything.

This year, I took up knitting and have become addicted. I made my first afghan this summer and I look forward to learning how to make socks and Fair Isle sweaters soon.

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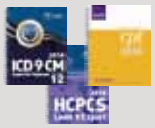	*Physician Bundle 1* ICD-9 1 & 2 • CPT® • HCPCS Level II	~~$299.95~~ **$169.95**
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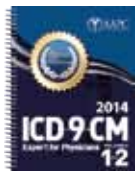

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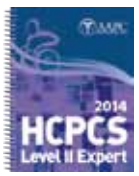

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