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On the Cover: One way that Pam Brooks, CPC, at Wentworth-Douglass Hospital in Dover, N.H. tackles a new specialty is by expanding her specialty-specific anatomy references. Cover photo by Brylye Collins Photography (http://brylyecollinsphotography.com) with photo enhancement by Michelle A. Dick.
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CLINICAL DOCUMENTATION IMPROVEMENT

Protect Your Practice Today and Prepare for ICD-10 Tomorrow

Up to 6 CEUs / $149.95 / Author: Quita Edwards, CPC, CPC-I, COSC

For many coders the single greatest hindrance to coding accuracy is the quality of documentation - including the degree of specificity, consistency, completeness, and timeliness. As reporting requirements and regulations increase, technology evolves, and ICD-10 looms on the horizon, it is becoming even more crucial for coders to work with physicians to improve their documentation today so they can protect their practice tomorrow.

This workshop reviews the timeliness of documentation issues and looks closely at case examples where improved documentation can minimize denials. Completing this workshop will protect and improve your clinic’s overall revenue stream using readily available tools.

Improved clinical documentation can:

- Allow for accurate coding diagnosis and procedures
- Minimize claim denials
- Ensure compliance
- Improve your cash flow
- Support the coming ICD-10 code set
Proposed Rule Makes Providers Subject to Fraud if Non-compliant

Feb. 16, 2012, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a proposed rule regarding reporting and returning overpayments. The deadline for returning overpayments would be 60 days after being identified or the date any corresponding cost report is due, if applicable, whichever is later. The proposed rule further specifies that any overpayment retained past the deadline could give rise to a false claim under 31 U.S.C. 3729.

Under-documented claims would have to be reported within 60 days of identification, as well. For compliance hotline reports, CMS proposes an obligation to make the “reasonable inquiry with deliberate speed after obtaining the information ...”

The proposed rule provides examples of “overpayments,” including:
- Incorrect, duplicate, or medically unnecessary claims
- Payments received in error under the Medicare Secondary Payer rules
- Incorrect interim payments
- Claims made under cost reports

It further defines the “person” obligated to report the overpayment as a provider or supplier, but not a beneficiary.

CMS proposes reconciliation of overpayment payment rules and a look-back period of 10 years, which coincides with the False Claims Act statute of limitations. The normal look-back period is one year absent good cause or fraud. This essentially rewrites the repayment obligation. Payments would be made via the Medicare Self-Referral Disclosure Protocol (SRDP).

Lastly, the rule proposes that inadequate finances should not be a reason to delay reporting an overpayment, but instead a provider should report an overpayment using the existing extended repayment schedule process outlined in chapter 4 of the Financial Management Manual.

Comments to this proposed ruling may be submitted online at www.regulations.gov/#!submitComment;D=CMS_FRDOC_0001-0905 until April 16, 2012.

AAPC Retains Apprentice Credential

Our committee, made up of both National Advisory Board (NAB) members and AAPC employees, has spent considerable time evaluating the votes and comments on the Certified Professional Coder-Apprentice (CPC-A) elimination proposal presented in January’s Coding Edge. In last month’s Coding Edge, we stated the voting was about 2:1 against the proposal.

The committee proposed ways to make the elimination a win for everyone involved; but in the end, it could not find a way to placate all interests. I believe we could better serve our CPC-As by eliminating the “A” tag, but feel something beyond the test must be done to replace the one to two years of required experience. That “something” is what most of the negative comments objected to. As a result, we will not make any change to our current CPC-A® credential; passage of the exam will earn you the CPC-A® designation. And, with either one or two years of qualifying experience, the “A” will be removed.

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While writing this month’s article at the end of February, the Centers for Medicare & Medicaid Services (CMS) announced the planned ICD-10 implementation will be postponed to yet another date. Although postponements in mandates and regulations have become commonplace over the past several years, this decision leaves many of us asking, “What next?”

More Time to Prepare
While many coders, administrators, educators, payers, and providers may view the additional time as an opportunity to meet their implementation timeline, others who have spent the past 18 months working diligently to prepare for ICD-10 may now be tempted to take this postponement as a time to kick back and relax. I’m not sure, however, how any health care professionals can relax when trying to implement all of the other multiple overlapping health care reform mandates, as well.

I think a better course of action would be to consult our own AAPC experts to learn how we should continue to prepare for ICD-10 in these uncertain times.

What Is the Next Step?
I was one of those members asking, “What next?” AAPC Vice President of ICD-10 Training and Development Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, said, “Continue to build strong relationships with your providers, working on improving documentation to support the ICD-10-CM code sets.” For the individual coder, “work on developing skills. If you haven’t already started, now would be a great time to work on deepening your knowledge of anatomy and pathophysiology.”

Instead of asking, “What’s next?” now is the time to ask, “What else?” With the additional time before the implementation date, what else can you do to better prepare for the ICD-10 implementation deadline?

Take a Moment to Reflect and Take Action
Consider what you know about ICD-10 and its potential benefits in terms of tracking and trending. Consider past moments when you thought, “If only we could track health management outcomes by reported diagnosis codes alone” or, “if we only knew how many of our type II DM patients were managing their condition by insulin without pulling the medical record.” Although there is a way to track diabetes mellitus (DM)/insulin patients using ICD-9-CM codes, how many practices use this code accurately and consistently to allow for proper tracking? Use this time to fulfill those “what ifs” by taking a more in-depth look at what ICD-10 can do for you and your practice. Build the necessary tools to use the new coding system to your advantage.

Many times over the past 18 months, I have heard that ICD-10 will level the field of coders. For a time, it will require ALL of us to read what many are only skimming: the ICD. This delay will give everyone time to get better acquainted with this often used tool. Review its guidelines, descriptions, and directions as you await the announcement of a new implementation date.

Million Dollar Question
Now for the burning question: How does the ICD-10 implementation delay affect AAPC proficiency testing? “If necessary, we will push back our timeline to match the change in the implementation timeline,” stated AAPC CEO and Chairman Reed Pew.

“The 24-month testing period around the implementation date—12 months prior to, 12 months after—will not change.”

Best Wishes,

Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P
President, National Advisory Board
April OPPS Updates
The Centers for Medicare & Medicaid Services (CMS) has posted April 2012 changes to billing instructions for payment policies implemented in the Hospital Outpatient Prospective Payment System (OPPS). The April 2012 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the quarterly HCPCS Level II, ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions.

Noteworthy Changes
For services provided on or after Jan. 1, 2012, the descriptor for CPT® 33249 has been changed to read “Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber.” Due to clinical inappropriateness, this has prompted the removal of HCPCS Level II code C1882 Cardioverter-defibrillator, other than single or dual chamber (implantable) from the list of device codes required to be billed with 33249 on the procedure-to-device edit list.

HCPCS Level II code C9733 Non-ophtalmic fluorescent vascular angiography (SI = Q2 and APC = 0397, vascular imaging) is assigned $154.87 for payment (minimum unadjusted copayment = $30.98) under the OPPS, effective April 1, 2012.


The April 2012 revisions to Integrated Outpatient Code Editor (I/OCE) data files, instructions, and specifications are provided in CR 7751.

AMA Makes Further Corrections to CPT® 2012

2012 Handbook Offers Something for Everyone
Find answers to your questions in the newly revised 2012 Local Chapter Handbook.

Here are just a few Q&A examples:

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Q: In September, I'm running for an office; how do I learn about it?
A: Refer to chapters 5 and 6.

Q: As treasurer, what do I need before writing a reimbursement check?
A: Look in chapter 13 to find out.

Q: 2012 Chapter of the Year is what we want! What do we have to do?
A: Chapter 11 will tell you everything you need to know.

Q: I've never been to a local chapter meeting. Why should I attend?
A: See chapters 1-13; and if you still aren't convinced, call your AAPCCA representative.

AAPC members can access the handbook on AAPC’s website: http://static.aapc.com/ppdf/LC_Handbook1.pdf. See for yourself what our local chapters are all about!
Ideal for those with responsibility for their organization’s implementation of ICD-10 and coders who want to understand the full implementation process. Our two-day Implementation Boot Camp will cover:

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- Importance of clinical documentation
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Take a logical approach to ICD-10 and see the international benefits.

You’ve probably heard stories about other countries’ ICD-10 implementation woes. Studies indicate it took a year or more for productivity to rebound in other countries following ICD-10 adoption—and most of those countries only implemented 20,000 or fewer new codes. In the United States, we are looking at implementing close to 70,000 ICD-10-CM codes.

My advice: Don’t panic! Taking a logical approach to “code volume” will put the United States in line with other countries. And if we learn the facts and plan well, we may even avoid extended productivity losses.

Grouping Codes Logically Makes ICD-10 Manageable

Although we have more clinical modifications than other countries, ICD-10 isn’t as overwhelming as it appears. For example, there is one code for a malunion in ICD-9; whereas in ICD-10, there is a seventh character extender that explains a malunion, attached to most fracture codes. The number of codes may be greater, but the organization of those codes is fairly intuitive.

Here’s another “volume buster” to consider: For conditions that can affect either side of the body, there are laterality choices in ICD-10. That means there are usually four code choices: one for the left side, one for the right side, a bilateral, and an unspecified. One condition equals four codes. By “grouping” conditions this way, we reduce these codes to a more manageable number.

Here’s another tip: Ignore subcategories of codes with an “unspecified” choice. Seriously work towards not having to use them. Some of the guidelines specifically state not to use them.

Documentation, Not Code Volume, Matters Most

Rather than the number of codes, what should concern us about ICD-10 is the specificity of those codes. The devil is in the details; and as coders, we need to update our knowledge of disease processes and anatomy, as well as improve our relationships with clinicians. We need to work with those who document the medical record, so all of the elements necessary in coding are captured.

For example, when coding hyperlipidemia, why do we so often choose “unspecified?” The patient has been treated for years, we have blood work, but we fail to change the code once the type has been determined. This requires communication with the provider to let him or her know that when the type has been determined, that information should be documented (and coded).

For coronary heart disease, documentation will need to include the type of graft and if the patient is also experiencing angina pectoris. This specificity will be necessary to apply ICD-10 codes.

Here’s a third, more complex, example that demonstrates why we need to improve our knowledge and communication with providers: The subcategory of F31.7 Bipolar disorder currently in remission includes choices for “full remission” and “partial remission,” and caveats for the most recent episode (e.g., manic, depressed, hypomanic, or mixed). Do you understand the differences between these codes and how they should be applied? Will your providers’ documentation stand up to the specificity? Teamwork will be necessary for success.

Speak the International Language: ICD-10

The true value of ICD-10 comes from the ability to share data in a meaningful way—not only within the United States, but also with other countries. Every country is responsible for making its own clinical modifications to ICD-10, but the core meaning of each code is the same in any language, allowing us to cross borders.

For example, C92.2 may be defined as Posostra bialaczka szpikowa, or Υποξεία μυελογενής λευχαιμία, or Ohne Angabe einer kompletten remission, or Leucémie myéloïde subaiguë, or Leucemia mieloide sua-acuto. Translation: Atypical chronic myeloid leukemia, BCR/ABL-negative.

Before we can realize the benefits of an “international language” and achieve full use of the code sets, we need to speak the same language within our own practices. There will be many challenges along the way, some of which may be due to our Z73.1 Personen, die das Gesundheitswesen aus sonstigen Gründen in Anspruch nehmen, or Άγχος, στρες, που δεν ταξινομείται αλλού, or Stres niesklasyfikowany gdzie indziej, or Accentuation de certains traits de la personnalité (Type A behavior pattern). Or, the problem might arise due to Z56.3 Personen mit potentiellen Gesundheitsrisiken aufgrund sozioökonomischer oder psychosozialer Umstände, or Rythme de
The devil is in the details; and as coders, we need to update our knowledge of disease processes and anatomy, as well as improve our relationships with clinicians.

travail pénible, or Στρεσσογόνο εργασιακό πρόγραμμα, or Stressful work schedule).

Whatever the challenge might be, it’s time for us to face it head on. Let’s move past meaningless statistics and face reality. The new coding system is coming, it’s long past due, and we need it. Our coders are the best in the business and we are up to this challenge. We can bring our physicians and others onboard with us for this journey.

Use the next few months to strengthen your skills, test your limits, and begin working with your teams. Open the lines of communication with your physicians to improve their documentation and begin the transition to ICD-10. Don’t try to do it all overnight, but instead work in stages. Start with the conditions your providers see most in their daily practice.

We can make a difference, one code at a time.

Rhonda Buckholtz, CPC, CPMA, CPC-I, is vice president of ICD-10 training and education at AAPC.

The devil is in the details; and as coders, we need to update our knowledge of disease processes and anatomy, as well as improve our relationships with clinicians.

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Diagnosis Code Overload

Know the difference between being thorough and going overboard.

Recently, a client asked me to review the medical records of a patient involved in a relatively minor motor vehicle accident (MVA). Three days after the accident, the patient went to see a chiropractor. The patient complained of neck pain, and some tingling and numbness in his shoulders. He said this pain was causing him to have difficulty sleeping and giving him headaches, and that bending, stretching, and walking made the pain worse. After an initial visit, his provider diagnosed him with the following:

- **847.0** Sprain of neck
- **723.4** Brachial neuritis or radiculitis NOS
- **739.1** Nonallopathic lesions, cervical region
- **728.4** Laxity of ligament (cervical)
- **728.85** Spasm of muscle (cervical)
- **729.1** Myalgia and myositis, unspecified
- **847.1** Sprain of thoracic
- **724.4** Thoracic or lumbosacral neuritis or radiculitis, unspecified
- **739.2** Nonallopathic lesions, thoracic region
- **728.4** Laxity of ligament (thoracic)
- **728.85** Spasm of muscle (thoracic)
- **719.7** Difficulty in walking
- **784.0** Headache
- **780.5** Sleep disturbances

**Red Flags Rise High**

The first thing that jumped out at me about this claim was the sheer number of diagnoses rendered. This type of coding is commonly referred to as “kitchen sink” coding. Typically, you expect to see three or four diagnosis codes—or perhaps a fifth diagnosis if the injuries are severe, and/or cover multiple body areas. Because that was not the case in this accident, I decided to take a closer look at the 14 different codes this provider cited.

**Takeaways:**

- Kitchen sink diagnoses can hurt patients in the long run.
- Coders have an opportunity to educate providers to avoid kitchen sink diagnoses.

Recent investigation uncovered the reasons why: ICD-9-CM codes 725-729 are used to diagnose rheumatism, excluding the back. The cervical and thoracic regions are both areas of the back, so using 725-729 would be improper in this case. Ligament laxity is typically used to describe a chronic condition (>30 days after the accident), whereas this diagnosis was rendered three days after the MVA.
Confused Coding

Although I’ve seen “headache” listed as a diagnosis plenty of times, this was the first time I had encountered 784.0 as a result of an MVA.

Similar reasoning applies to 728.85 (cervical and thoracic myospasms), which also falls within category 725-729 (rheumatism excluding the back), and should not have been used to describe this patient’s injuries. Neither 728.4 nor 728.85 are applicable diagnoses in this case.

The use of 719.7 (difficulty walking) also stood out. Applied correctly, 719.7 is for patients who suffer from difficulty walking, typically as a result of degenerative and chronic joint disease, which clearly was not the case here. The notes did not substantiate the patient could not walk, had developed a limp, or other walking abnormality; the records merely indicated that the patient claimed to experience more pain while walking (among other activities). In short, nothing in the documentation warranted reporting 719.7. As well, it would be premature to diagnose the patient with abnormal gait (781.2 Abnormality of gait). Should the symptoms persist, however, the more appropriate codes would be E813.1 Motor vehicle traffic accident involving collision with other vehicle injuring passenger in motor vehicle other than motorcycle, as well as E929.0 Late effects of motor vehicle accident.

Read the Guidelines

Although I’ve seen “headache” listed as a diagnosis plenty of times, this was the first time I had encountered 784.0 as a result of an MVA. ICD-9-CM codes 780-799 are for “Symptoms, Signs, and Ill-Defined Conditions.” The ICD-9-CM manual explains that these codes are to be used:

a. for cases in which a more specific diagnosis cannot be made even after investigating all the facts bearing on the case;
b. indeterminate or transient signs and symptoms;
c. provisional diagnoses in a patient who failed to return;
d. for cases referred elsewhere for investigation or treatment before a diagnosis was made;
e. when a more precise diagnosis was not available for any other reason; and/or
f. for certain symptoms which represent important problems in medical care and which might be desired to classify in addition to an unknown cause.

In this case, using 784.0 to describe the patient’s headaches does not meet the criteria for this range of codes. The facts of the case are pretty clear: The patient claims to have headaches as a result of the accident three days prior. The appropriate diagnosis would be 339.21 Acute post-traumatic headache.

Similar reasoning applies for 780.5 (sleep disturbances). The patient’s difficulty sleeping is not an isolated symptom of unknown origin; it is a direct result of the pain in his upper back caused by the accident. The patient stated his neck pain makes it hard to get comfortable enough to fall asleep at night. Based on the documentation, 780.5 is not warranted.

Double Check “Other” and “Unspecified” Codes

In my experience, the use of “other” and “unspecified” diagnosis codes can be viewed as a red flag. In this case, codes 780-799 are red flags because the origins of the patient’s symptoms are well known. Current ICD-9-CM, as well as ICD-10, contains a plethora of available classifications and subclassifications to describe a patient’s condition(s) in remarkable detail.

When it comes to diagnosis codes, there is a fine line between being thorough and going overboard. Physicians may diagnose the kitchen sink in an attempt to justify all the treatments rendered, or to exaggerate a patient’s injuries. Kitchen sink diagnosis coding can hurt patients in the long run by assigning diagnoses to their health history that may not have been applicable.

When trying to establish best practices and avoid kitchen sink diagnosis coding, ask yourself these questions:

• Are all of these codes medically indicated by the patient’s records?
• Are any of the rendered codes merely symptoms of other codes?
• Are the rendered codes as accurate and precise as possible, given the supporting medical documentation?

As a coder, you have the opportunity to educate the medical community about proper coding. Look for ways to show the benefits of being precise with the codes you choose. Diagnosis coding is always a case in which quality is more important than quantity.

Jeremy Reimer, CPC, is the president of Medical Coding Litigation Services, which provides medical coding and billing analysis to insurance carriers, legal counsel, and companies involved in personal injury litigation. He is an author and frequent lecturer on medical coding and billing fraud. Jeremy is also an adjunct professor at Hillsborough Community College, where he teaches Advanced Medical Coding. He can be reached at: jreimer@mcls.co.

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April 2012
15
Physician Self Referrals and Compliance: What You Should Know

To keep designated health services in the clear, know Stark regulations and their exceptions.

Physicians and their practices are undergoing increased government scrutiny with regard to their referrals and financial relationships for health care services. At the heart of this scrutiny lies the physician self-referral law, known as the Stark law (provided in full detail at section 1877 of the Social Security Act, and codified at 42 U.S.C. section 1395nn). As a coding professional, you should understand the basic principles of Stark law so that you are able to recognize when a possible infringement may be taking place.

Self Referrals Pose Conflict of Interest in Patient Care

Congress originally passed the Stark law in 1989 in response to a growing concern about physicians referring patients to laboratories where the physician had a financial interest. This posed a conflict of interest; Congress’ concern was that physicians who stood to benefit financially from ordering laboratory tests were likely to order more tests, including more complex tests, even when such services were unnecessary.

Following enactment, Congress expanded the Stark law’s prohibition to include additional designated health services (DHS) and extended its application to the Medicaid program. In 1997, Congress added a provision authorizing the secretary of the Department of Health & Human Services (HHS) to issue written advisory opinions concerning whether a referral relating to DHS (other than clinical laboratory services) is prohibited under the Stark law. Congress also authorized the secretary in 2003 to publish an exception to the physician self-referral prohibition for certain arrangements in which the physician receives necessary non-monetary remuneration used solely to receive and transmit electronic prescription information. They established a temporary moratorium on physician referrals to certain specialty hospitals in which the referring physician has an ownership or investment interest, as well.

The Centers for Medicare & Medicaid Services (CMS) has published a number of regulations interpreting the physician self-referral statute over the years. These rules were published in phases and are referred to as “Phase I, II, and III.” An overview of the Stark law’s regulatory history can be found on the CMS website: www.cms.gov/PhysicianSelfReferral/01_overview.asp#TopOfPage.

Get to the Core of Stark Law

At its core, the Stark law prohibits physician referrals to entities providing certain DHS in which the physician (or his or her family member) has an ownership or compensation interest, unless an exception applies. The law further prohibits the entity from presenting, or causing to be presented, a claim to bill Medicare or Medicaid for any DHS provided pursuant to a prohibited referral. Due to this broad language, the law also establishes many exceptions.

Under Stark (42 CFR at § 411.351), physician means:

- A doctor of medicine or osteopathy
- A doctor of dental surgery or dental medicine
- A doctor of podiatric medicine
- A doctor of optometry
- A chiropractor

A referral is a request by a physician for, or ordering of, or certifying necessity for, any designated health service for which payment be made under Medicare Part B. DHS personally performed or provided by the referring physician are specifically excluded from the referral definition; however, the service is not considered to be personally performed by the referring physician if the designated health service is performed or provided by the referring physician’s employees, independent contractors, or group practice members.

DHS cover a broad range of health care items and services including:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment (DME) and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
Because the regulations define certain DHS by CPT® and HCPCS Level II codes, CMS maintains a list of CPT® and HCPCS Level II codes identifying those items and services...

**CMS Identifies DHS Codes**

Because the regulations define certain DHS by CPT® and HCPCS Level II codes, CMS maintains a list of CPT® and HCPCS Level II codes identifying those items and services included within the categories referenced above (see www.cms.gov/PhysicianSelfReferral/40_List_of_Codes.asp#TopOfPage). CMS updates this list annually to correspond with CPT® and HCPCS Level II manual updates in Medicare coverage and payment policies. The updated code list is also published in the *Federal Register* as an addendum to the annual Physician Fee Schedule final rule, which is published annually in November with a Jan. 1 effective date for the following year.

The DHS categories defined by the code list include:

- Clinical laboratory services
- Physical therapy services, occupational therapy services, outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies

The following DHS categories are defined without reference to the code list (42 CFR §411.351):

- DME and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

**Bottom Line: Stay Stark Compliant**

When analyzing physician referral activity, physicians and entities must ask two questions:

- Is there a financial relationship (a compensation arrangement or an ownership interest) between the referring physician (or his or her family member) and the entity that will provide the designated health service?

If the answer to both of these questions is "yes," the referral is prohibited under Stark law unless one of the statutory exceptions applies. Stark exceptions are generally divided into three categories, including:

1. General exceptions
2. Ownership/investment interest exceptions
3. Certain compensation arrangements

Learn more about these exceptions by visiting CMS’ physician self-referral website. Stark law exceptions can be viewed in their entirety at: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=ee078c3967196725d58/26f352aaef0&rgn=div6&view=text&node=42:2.0.1.2.11.10&idno=42.

**Seek Professional Advice on Referrals**

Penalties for referrals violating the Stark law can be substantial. If a referral is made violating the Stark law and payment is received by the entity providing the designated health service, penalties can include: civil penalties up to $15,000 for each illegal referral, exclusion from participation in federal health care programs, denial of payment for services, refunding of payments received, a fine of up to $100,000 for each illegal cross-referral arrangement, and civil penalties up to $10,000 per day for failing to report violations. Physician and entity compliance with the Stark law is mandatory.

Because non-compliance with the Stark law requirements poses financial impact, physicians and entities developing arrangements that include referrals for DHS should retain legal counsel to make sure these referrals fit within one of the Stark exceptions.

*Julie E. Chicoine, Esq., RN, CPC,* is senior attorney for Ohio State University Medical Center. Ms. Chicoine earned her Juris Doctor degree from the University of Houston Law Center. She also holds a Bachelor of Science and a nursing degree from the University of Texas Health Sciences Center at Houston. She has written and spoken widely on health care issues, and is an active member of the AAPC community.
Move Over Obsolete Pain Management Coding

Part 1: Make room for the latest in CPT® coding.

CPT® 2012 brings important changes to pain management coding. In the first of this two-part series, we’ll:

- Review the revised coding guidelines for sacroiliac (SI) joint injection.
- Clarify the methodology for determining when to use the “open” versus “percutaneous” codes for disc procedures, and corresponding changes to code 62287.
- Explain how to code the use of a catheter for a single epidural injection.
- Go over the new codes for facet joint nerve destruction.

SI Joint Injections Include Imaging Guidance

Code 27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed has been revised for 2012 to include image guidance by fluoroscopy or computed tomography (CT) to confirm intra-articular needle positioning. Arthrography is also included, when performed. The corresponding radiology code (73542) has been deleted, and a new parenthetical note directs providers to use 27096 for arthrography. CPT® continues to direct providers to append modifier 50 Bilateral procedure for bilateral injections.

For example: The physician performs a right SI joint injection for sacroilitis with 6 mg of steroid and 1 mL of 0.5 percent local anesthetic. Intra-articular needle placement was verified fluoroscopically with an injection of 0.5 mL low osmolar contrast. In this case, physician coding would be 27096-RT x 1 with a diagnosis of 720.2 Sacroilitis, not elsewhere classified. Modifier RT indicates that the injection occurred on the right side.

Per CPT® Assistant (April 2004), CPT® 20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa) historically has been reported for an SI joint injection without image guidance; however, a parenthetical note in CPT® 2012 now instructs, “If CT or fluoroscopic imaging is not performed, use 20552 [Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)].”

Note: Medicare HCPCS Level II codes G0259 Injection procedure for sacroiliac joint; arthrography and G0260 Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography, used for ambulatory surgi-
The use of an endoscope to perform a procedure does not determine the procedure coding; rather, the physician’s visualization of the disc, spinal cord, and neural space does.

Code 62287 Now Specifies Needle-based Procedures

CPT® code 62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with disography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar has been revised to specify a needle-based procedure that may include an endoscopic approach. The procedure removes part of the nucleus pulposus, the gel center, from a herniated disk, to decrease pressure on a spinal nerve root and relieve pain.

Code 62287 now includes fluoroscopic guidance, as indicated by the revised code descriptor. Also included and not separately reportable are percutaneous aspiration with the nucleus pulposus (62267), discography injection (62290), and diagnostic/therapeutic lumbar injection (62311). You should continue to report 62287 as a single unit of service for “single or multiple levels,” and only for the lumbar spine.

The “Spine and Spinal Cord: Injection, Drainage or Aspiration” section guidelines now clarify the difference between indirect versus direct visualization. The use of an endoscope to perform a procedure does not determine the procedure coding; rather, the physician’s visualization of the disc, spinal cord, and neural space does.

The new guidelines indicate, “Percutaneous spinal procedures are done with indirect visualization (e.g., image guidance or endoscopic approaches) and without direct visualization. The use of an endoscope to perform a procedure does not determine the procedure coding; rather, the physician’s visualization of the disc, spinal cord, and neural space does.

The new guidelines indicate, “Percutaneous spinal procedures are done with indirect visualization (e.g., image guidance or endoscopic approaches) and without direct visualization (including through a microscope)” and “Endoscopic assistance during an open procedure with direct visualization is reported using excision codes (e.g., 63020-63035).” For a non-needle-based technique for percutaneous decompression of nucleus pulposus of intervertebral disc, CPT® directs you to 0274T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic. 0275T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar.

For example, for percutaneous L4-L5 disectomy (PLD) with aspiration under fluoroscopic guidance for L4-L5 bulging disc, physician coding is 62287* (one unit of service) with a diagnosis of 722.10 Lumbar intervertebral disc without myelopathy.

For bilateral L4-L5 percutaneous decompressive laminectomy under fluoroscopic guidance, and epidurogram confirmation for central lumbar stenosis with neurogenic claudication, the proper coding is 0275T (single unit of service) with 724.03 Spinal stenosis; lumbar region, with neurogenic claudication.

In a final example, endoscopically assisted open hemilaminectomy with right L4 nerve root decompression for L4-L5 disc herniation would be reported 63030-RT and 722.10.

Code Diagnostic/Therapeutic Injections by Location, Duration

CPT® section guidelines and code descriptors for 62310 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic and 62311 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic have been revised, to include injection(s), including any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic and 6275T Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic.

If the catheter is left in place to deliver substance(s) over a prolonged period (i.e., more than a single calendar day), either continuously or via intermittent bolus, report instead 62318 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic or 62319 Injection(s), including indwelling catheter placement, continuous infusion or intermit-
Image guidance (fluoroscopy or CT) is now required, and is no longer separately billable ...

Image guidance (fluoroscopy or CT) is now required, and is no longer separately billable with either 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid) or 77012 Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation. Facet joint nerve destruction continues to be considered a unilateral procedure; you may append modifier 50 for bilateral facet joint nerve destruction.

For example, to describe radiofrequency ablation of the C3, C4, and C5 medial branches, you would report 64633, 64634 because the sensory innervation to two facet joint levels, C3-C4 and C4-C5, was neurolysed. For bilateral L3-L4, L4-L5, and L5-S1 facet joint neurolysis (i.e., L2, L3, and L4 medial branches and L5 dorsal ramus), correct coding would be 64635-50, 64636-50 x 2 units of service (or, depending on your payer, 64635-LT Left side, 64635-RT and 64636-LT x 2, 64636-RT x 2).

**Note:** Continue to report pulsed radiofrequency ablation (which is not considered a method of destruction) using an unlisted procedure code (64999 Unlisted procedure, nervous system).

Next month, we’ll discuss revised combination codes for pump refill and programming, coding methodology changes for “simple” versus “complex” neurostimulator programming, and related concerns.

**Report Facet Joint Destruction per Joint, Not per Injection**

With the deletion of 64623–64627, coding for paravertebral facet joint destruction is now based on destruction of the sensory innervation to each facet joint, not per facet joint nerve, as in the past:

- **64633** Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
- **+64634** each additional facet joint (List separately in addition to code for primary procedure)
- **64635** lumbar or sacral, single facet joint
- **+64636** lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
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Spine Reimbursement Sees a Major Impact

2012’s bundling of procedures and assigning of “experimental” T codes can hamper provider reimbursement.

Changes to CPT® 2012 spinal codes and coding guidelines have an important impact on reimbursement, new technologies, and the advancement of patient care. Let’s review the changes you’ll need to know to properly document and code these surgical cases.

63030 Not for Minimally Invasive Lumbar Decompressions

Compared to 2011, you’ll notice a discreet difference in the coding requirements for decompressions of the spine. Discectomy, hemilaminectomy, and interspace decompression now require greater detail about the surgical approach.

For example, 63030 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar now describes an “open” procedure only (as does 63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical). You may no longer report 63030 for minimally invasive (i.e., endoscopically assisted) lumbar procedures, as in previous years. Instead, 62287 and 0275T now cover percutaneous and endoscopic approaches:

62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar

Note that 62287 and 0275T bundle (include) many related procedures, such as fluoroscopy, imaging, discogram, etc. The bundled services may not be coded separately. The codes also describe procedures performed at either single or multiple levels; 0275T further describes either unilateral or bilateral procedures.

When selecting among 63030, 62287, and 0275T, you must review documentation language carefully to differentiate the approach and find the specific terminology necessary to support the chosen code. Look for terms such as “percutaneous,” “cannula,” “fluoroscopy,” “tubular,” “intralaminar,” “port incision,” and “endoscopic” to identify decompression by minimally invasive technique as described by 0275T and 62287. Further clarification is required to determine a needle-based approach (62287) versus a non-needle-based approach (0275T). The language here is very specific.

Minimally Invasive Fusion Now a Category III Procedure

Descriptors for 22610 Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed) and 22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed) have been revised (removing “without”) for 2012 to require that fusion include a transverse technique. This is another critical change. To report a minimally invasive approach, the coder must now look to Category III codes:

0220T Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic

0221T lumbar

Takeaways:

- Changes to spinal coding in CPT® 2012 will have an impact on coding and reimbursement, and they reflect advancements in technique.
- Minimally invasive fusion is a T code, making reimbursement more difficult.
- Resubmissions and additional documentation may be necessary to have many spinal codes reimbursed.
Surgeons performing these minimally invasive procedures (and facilities offering them) will likely feel a significant economic crunch with the shift from the traditional CPT® Category I code submission to T code submission.

As evidenced by the code descriptors, 0220T-0222T include fusion as well as instrumentation, grafting, etc. Prior to this year, these procedures have been coded separately in addition to 22610 and 22612; in 2012, the new codes cover everything.

**Understand the T code Challenge**

Category III CPT® codes, also called temporary codes or T codes, represent emerging medical technologies that have not yet been approved by the U.S. Food and Drug Administration (FDA). Unfortunately, payers often don’t acknowledge T codes as a viable code set, claiming that the procedures are experimental and not covered. To make matters worse, T codes are not assigned relative value units (RVUs). The lack of RVUs is significant because it signals to payers that a procedure or service is experimental, unconventional, and/or an unacceptable medical treatment. This could mean that effective procedures and services assigned T code status never “catch on,” due to a lack of reimbursement.

As an example, there are difficulties using T codes for preauthorization, submission, and payment for services going back to the development and implementation of artificial spinal disc surgery. The artificial disc coding and reimbursement example amply illustrates how T code status has nearly destroyed the artificial disc procedure as an adjunct procedure to the spine surgeons’ repertoire.

In 2005, practices using unspecified procedure codes to report artificial disc procedures began using new Category III codes 0090T-0092T (total disc arthroplasty). Payers began treating these procedures as experimental. Years later, even now that CPT® directs coders to use 22856 (cervical) and 22857 (lumbar) to report artificial discs, many payers refuse to yield and pay for the procedures—for the most part due to past medical determinations.

In reviewing the 2012 CPT® changes, we see that several established spinal procedures have now been transferred to T codes. As mentioned, these include endoscopic discectomy (lumbar, 0275T; as well as 0274T Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic) and facet fusion (thoracic and lumbar, 0220T-0222T; as well as 0219T Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical). Both endoscopic discectomy and facet fusion are widely accepted surgical procedures, with a significant history of success within the spine community. Surgeons performing these minimally invasive procedures (and facilities offering them) will likely feel a significant economic crunch with the shift from the traditional CPT® Category I code submission to T code submission.

Some payers understand the difficulties posed by T codes and have responded by providing coverage and reimbursement advisories on their websites, or may engage in “presurgical” discussions regarding coverage and reimbursement. Whenever there’s doubt, it’s best to be proactive and communicate directly with your payer representatives.

Proactive and cooperative communications will reduce post-surgical denials. Physicians will play a key role in educating and encouraging carriers to approve procedures if they can communicate effectively about the medical benefits to the patient.
Don’t Give Up Reimbursement without a Fight

Practices and facilities will be required in 2012 to reauthorize any previously authorized procedures that are now reported with a T code. Practices that do not confirm authorization may find themselves—as they have in the past with the artificial disc procedures—receiving denials for what are suddenly considered to be experimental or noncovered procedures.

Setting the standard for reimbursement if preauthorization is granted is a secondary challenge. Even with preauthorization and proven reimbursement history for endoscopic discectomy and minimally invasive facet fusion, the practice or facility will face challenges. T codes generally result in an immediate denial, regardless of approval status, and require in-depth appeals and audits on a regular basis. The ability to navigate these challenges requires continued communication via the appeals process. Practices will be forced to provide supportive documentation of the preauthorization, previous payment history for similar procedures, and a “stick to it” attitude toward an acceptable reimbursement solution.

One of the best defenses is a great offense. When dealing with T codes, pursue payer authorization in writing, inclusive of the CPT® codes and the patient’s diagnosis and name, specific to the individual case. This basic document is often considered unnecessary until the denial is received, and getting it up front will save a great deal of effort.

Fortunately, in the case of endoscopic discectomy and/or minimally invasive facet fusion, a practice or facility may look to historic payments from codes 63030, 22610, and 22612 to support the reimbursement levels they expect for the T codes that now apply. Review practice reporting to identify payment trends (both highs and lows) to develop an acceptable fee range for these procedures in your geographic area. This will be helpful in formulating and supporting reimbursement appeals.

Industry is not likely to embrace technologies if surgeons, unsure of reimbursement, are hesitant to perform new procedures. This may hurt patients the most. Developing technologies should involve open discussions about medical necessity, CPT® applications, and reimbursement issues during the research and development phase to reduce the possibility of undesirable or unacceptable coding and reimbursement results. Sharing in new developments requires commitments from industry, physicians, patients, and insurers if we are to continue the process of improved medical treatments and medical successes.

Barbara Cataletto, MBA, CPC, is CEO of Business Dynamics LLC and the founder and CEO of CaseCoder™.

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Quick Tip

Learn New ICD-9-CM Language for 317-319

Significant changes to the descriptors for code range 317-319 in 2012 ICD-9-CM reflect new definitions of mental retardation.

- **317** Mild mental retardation Intellectual disabilities
- **318** Other specified mental retardation Intellectual disabilities
- **318.0** Moderate mental retardation Intellectual disabilities
- **318.1** Severe mental retardation Intellectual disabilities
- **318.2** Profound mental retardation Intellectual disabilities
- **319** Unspecified mental retardation Intellectual disabilities

To understand why it was necessary to discard “mental retardation” and use instead “intellectual disabilities,” we must first understand the meaning of the terms.

**Mental retardation** (MR) is a generalized disorder characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors appearing before adulthood. It has historically been defined as an intelligence quotient (IQ) score under 70, but the definition now includes both a component relating to mental functioning and one relating to individuals’ functional skills in their environment. IQ is no longer the only factor.

**Intellectual disability** is a broad concept encompassing various intellectual deficits, including MR too mild to properly qualify as MR, various specific conditions (such as a specific learning disability), and problems acquired later in life through acquired brain injuries or neurodegenerative diseases such as dementia. Intellectual disabilities may appear at any age.

Although the clinical term mental retardation is a subtype of intellectual disability, the latter is now preferred in most English-speaking countries. “Intellectual disability” has begun to replace “mental retardation” in United States’ official documents following the passage of “Rosa’s Law” in 2010.

The ICD-10-CM (draft) retains the term “mental retardation” in the following codes:

- **Mental retardation (F70-F79)**
  - **F70** Mild mental retardation
  - **F71** Moderate mental retardation
  - **F72** Severe mental retardation
  - **F73** Profound mental retardation
  - **F78** Other mental retardation
  - **F79** Unspecified mental retardation

By Rahul Srivastava, MD, CPC

A&P Quiz

Think You Know A&P? Let’s See …

Having thorough knowledge of anatomy and pathophysiology (A&P) will be crucial when coding diagnoses with ICD-10 because of the expanded clinical detail it demands. ICD-10-CM classifies migraines to the type, such as hemiplegic, chronic, persistent, ophthalmoplegic, menstrual, abdominal, etc. To appropriately code migraines in ICD-10, you need to understand the type as well as complications that are inherent to migraines.

Test yourself to find out where your A&P skills rank:

**Q** Menstrual migraines are primarily caused by:

A. Children  
B. Three months of headaches  
C. Extreme pain  
D. Estrogen

The answer is on one of the pages in this issue.

By Rhonda Buckholtz, CPC, CPMA, CPC-I

Rhonda Buckholtz, CPC, CPMA, CPC-I, is vice president of ICD-10 Training and Education at AAPC.
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Seek Specialty Opportunities and Overcome Their Challenges

The benefits of taking on a new specialty are worth the initial extra legwork.

The trend toward comprehensive patient care will create a demand for many new multi-specialty practices. As practices expand, the need for specialty coders will, too. But these jobs won’t come without challenges. Even experienced coders can become overwhelmed when learning a new medical specialty, with all the unfamiliar procedures, terminology, and payer guidelines. With a fair amount of organized and careful front-end prep work, coders can overcome the obstacles of learning a new specialty and reap the rewards.

Review the Data and Do Your Homework

If your new medical specialist has recently worked in another practice setting or facility, you may be able to get a list of his or her coding activity over the past year. When a provider joins a new group, the accounting department usually has access to this historical data to determine the return on investment (ROI) they can expect based on past performance. This list can provide you with insight as to the kind of work your specialist will do at your site.

If possible, sort the list of CPT® codes from the most- to least-commonly performed procedures. This will give you an idea of the scope of the new provider’s practice, and where you’ll need to focus your efforts in terms of learning new coding guidelines. You should also review the list against the most up-to-date version of CPT® to make sure the codes are still current. Keep in mind, however, that any previous coding and billing should be viewed as “suspect.” That is not to say you should assume the provider was billing incorrectly or fraudulently; rather, only use this historical data as a guideline. After careful review, move forward. This will help to ensure your own correct coding.

Takeaways:

- Expand yourself and your career by moving into a new specialty.
- Work with your physician to learn about the specialty.
- Educate yourself on all things coding regarding the specialty.

It’s unlikely that diagnosis coding will be included in the financial data because physician coding and billing is not reimbursed based on diagnosis. It’s a good idea, however, to research the conditions and
illnesses for the procedures you’ve identified and to learn about the related anatomy, pathophysiology, and typical treatment plans. Familiarizing yourself with common courses of treatment will enable you to recognize when your provider has gone over and above what is expected. If you come across unfamiliar terminology or concepts, look them up. This is an excellent way to learn about your new specialty or to refresh your memory.

Meet with Your Doctor
To better familiarize yourself with your new specialty, secure a time to meet with your new provider to learn about the types of services she provides. Ask if there are any videos or books you could review that would give you a visual perspective of her work. Alternatively, there are a fair amount of surgical procedures available on YouTube. Or, you can Google any of the procedures you are unfamiliar with. To prevent billing errors, ask your provider what procedures she will perform in the office verses in an outpatient surgery or inpatient operating room setting.

If part of your responsibility is charge capture, you can also use this meeting to decide which services belong on an office fee ticket, and which services might need to be on billing cards or order sheets for work done in the facility setting. If your provider will be using an electronic health record to document her work, you can offer your expertise as a coder to become a part of the template development team by offering advice on documentation guidelines.

After you’ve gotten a pretty solid idea of your provider’s scope of practice and the procedures you can expect to see, start doing compliance research to support your correct coding. Access the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule (PFS) (www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx) to determine if any of the identified procedures or diagnostics will require you to bill globally or with modifier 26 Professional component. This is also where you can determine whether an assistant surgeon is allowed, what the global days are, and what the associated relative value units (RVUs) are.

Note: For more information about the Medicare Physician Fee Schedule (MPFS) database, see “Use the PFS RVF to Expand Your Coding Knowledge,” April 2011 Coding Edge, pages 42-44.

Know Specialty-specific Code Guidelines
To make sure you’ll recognize which codes cannot be bundled, run commonly-used codes through the National Correct Coding Initiative (NCCI) edits, and take the time to revisit the modifier lists and definitions to determine if any modifier use would be required in certain circumstances. You’ll want to make sure your chargemaster reports the appropriate fees associated with those modifiers that affect reimbursement, so you aren’t under- or overcharging.

If any unlisted codes show up as part of your new provider’s scope of practice, you will have to investigate the most appropriate comparable listed code. You should also review HCPCS Level II and Category III codes to make sure none of these are being overlooked regarding your new provider’s billable services, equipment, or new technology.

Visit the websites of both CMS and your local carrier to identify any national and local coverage determinations (LCD) related to the list of CPT® codes you’ve identified. It can be helpful to gather all of this information into either a notebook or on your desktop as a virtual procedures manual for later reference. Just remember to update it every year.
Expand Your References

Medicare isn’t your only payer, of course, so visit all of your payer websites or contact your provider representatives to learn if they have any specific coverage determinations based on your list of identified CPT® codes. Depending on your new specialty, some procedures or surgeries may be considered experimental, cosmetic, or non-covered, or require payer-specific modifiers or other billing guidelines.

Professional associations your providers are affiliated with are useful resources for finding this specialty-specific information. For example, American College of Obstetricians and Gynecologists (ACOG), Society of Thoracic Surgeons (STA), and American Association of Orthopedic Surgeons (AAOS) all have websites with valuable information for practice management and coding. Often, these resources provide specialty-specific coding and billing workshops, newsletters, or coding services that can help you navigate the ins and outs of your new specialty.

AAPC is also a significant resource for specialty coders. By logging onto the member forum (www.aapc.com/memberarea/forums/), you can pose questions or search for previously asked questions in a number of specialty areas, with answers usually provided by senior coders who routinely provide links to regulatory guidance. Most importantly, you can obtain additional training and specialty certification through AAPC’s conferences, workshops, and specialty certification examinations.

Networking through your local AAPC chapter can help introduce you to coders who may have experience in your new specialty. You can also arrange to be on the mailing lists of neighboring local chapters, so if they are holding a meeting regarding your specific specialty, you can attend, learn, and network.

Learning a new coding specialty can be a fun and interesting challenge if you’re motivated and apply a systematic and careful approach to setting up your coding and billing protocols. You can also use this approach to prepare for a job interview in a new and exciting specialty. Take advantage of available resources to add value to your current employer and add experience to your resume.

Pam Brooks, CPC, is the physician services coding supervisor at Wentworth-Douglass Hospital in Dover, N.H. She holds a Bachelor of Science degree in Adult Education and Workplace Training from Granite State College, and is working on her master’s in Health Administration at St. Joseph’s College of Maine. She is a past secretary of the Seacoast-Dover N.H. AAPC local chapter.
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Surgical Preps:
When Do You Code Them?

From A to Xenograph, specific language in the operative report should support the use of surgical prep codes.

**Takeaways:**
- Be prepared to fully document skin graft site prep.
- Know how much and where.
- Don’t confuse site prep and wound management.

CPT® 2012 adds new instruction and definitions for surgical preparation of skin graft recipient sites (15002-15005). The area over which a skin graft/replacement is laid must be free of infection or disease. If it is necessary to cleanse the site, surgical preparation may be reported in addition to skin replacement/skin substitute surgery (15100-15278).

**Note:** For more information on skin replacement and skin substitute procedures, see Terri Brame’s, MBA, CPC, CGSC, CPC-H, CPC-I, CHC, article, “Grasp New Coding Details of Skin Replacement Surgery,” in the March 2012 Coding Edge, pages 28–31.

**Know Where, How Much, Skin Is Prepared**
Specific language must appear in the operative report to support surgical prep codes. A statement such as, “I prepped and draped the site” is inadequate because prepping and draping are routine with any surgical procedure. Rather, the documentation must specify how the preparation was accomplished prior to performing skin replacement/substitute surgery. For example: “The infection of the wound was so profound that it required extensive cutting and cleansing through to deep layers of subcutaneous tissue.”

When supported by documentation, site prep codes are assigned according to the anatomic area and total body surface area involved:

- **15002** Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children
  +15003 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)

- **15004** Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children
  +15005 each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)

For preparation of wounds on the trunk, arms, and/or legs, report 15002 for the first 100 sq cm of site prep. For additional preparation (beyond 100 sq cm) in the same anatomic areas, report add-on 15003. Because 15003 is an add-on code, report it only in addition to 15002.

Likewise, for preparation of wounds of the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, report 15004 for the first 100 sq cm of site prep. For additional preparation (beyond 100 sq cm) in the same anatomic areas, report add-on 15005—again, only in addition to 15004.

Surgical preparation may be reported only once per wound. If the wound is prepared, but not grafted (for instance, grafting won’t occur until the next day), minimal preparation of the wound bed is included in the graft code, as is removing a previous graft.

Because site prep usually will accompany skin replacement surgery (15100-15278), modifier 51 Multiple procedures may be added to site prep codes 15002 or 15004 (for payers that require this modifier).

Do not apply modifier 51 to 15003 or 15005; as add-on codes, they are “multiple procedure exempt.”

For example, a 2-year-old girl developed tinea nigra over her face, including her scalp, cheeks, mouth, and neck. The dermatomycosis caused severe contamination and some necrotization that encompassed 4 percent of her body surface. The surgeon thoroughly debrided the infected area before placing acellular dermal allograft over it. Proper coding is:
A statement such as, “I prepped and draped the site” is inadequate because prepping and draping are routine with any surgical procedure.

- **15277** Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children, for the first 1 percent of body area treated with allograft (human donor skin substitute).

- **+15278** Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) x 3 units, to describe placement of allograft on the additional 3 percent of body area.

- 15004 to describe surgical prep of the first 1 percent of body area (modifier 51 may be appended for those payers that require it).

- 15005 x 3 units, to report preparation of the additional 3 percent of body surface area.

Modifier 51 is not appended to 15278, 15777, or 15005 because these are add-on codes. The ICD-9-CM code for *Tinea nigra* is 111.1.

In a second example, a 47-year-old man suffered seven burns to his chest following an industrial accident six months ago. He now presents with infected and very painful scar tissue from three of the (third-degree) burns to the chest wall. Three full-thickness skin grafts are performed, taken from the right hip, including closure of the hip sites, as follows:
- Right sternal area, 6 x 4 sq cm
- Right sternal area, 9 x 6 sq cm
- Left sternal area, 8 x 5 sq cm

The surgeon discovered extensive eschar in each of these areas, which required extensive debridement. Proper coding is:

- **15200** Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less for the first 20 sq cm of the trunk treated with full thickness graft. The total area grafted in this case is 118 sq cm.

- **15201** Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) x 5 units to report the additional 98 sq cm (beyond the initial 20 sq cm) of the trunk treated with full thickness grafts.

- 15002 for the first 100 sq cm of site prep.

- 15003 for the additional 18 sq cm of site prep.

For a diagnosis, you are not coding burns, but rather a late effect of burns. Report residual effect of the scar (709.2 *Scar conditions and fibrosis of skin*), followed by the late effect of a burn classified to category 942 (906.8 *Late effect of burns of other specified sites*).

**Distinguish Site Prep from Wound Management**

Codes 15002-15005 apply specifically to describe the work of “preparing a clean and viable wound surface for placement of an autograft, flap, skin substitute graft or for negative pressure wound therapy,” according to CPT® guidelines. Surgical prep codes would not be reported for removal of nonviable tissue or debris in a chronic wound when it is left to heal by secondary intention. When a wound requires serial debridement, report active wound management (97597-97598) or debridement (11042-11047). If a wound requires negative pressure wound therapy, 15002-15005 are applicable in addition to 97605-97606.

For instance, a 51-year-old woman presents for sharp debridement of a non-healing open wound to her arm. The wound resulted from an automobile collision three weeks ago, in which the patient was a passenger. Cleaning of the wound reveals remaining glass shards going down to tendon. Total area involved is 38 sq cm.

Because the non-healing wound is treated with debridement classified under Active Wound Care Management, report 97597 *Debridge-...
Skin Replacement Surgery, Skin Substitutes, Flaps, and Grafts

Acellular dermal matrix (ADM) - a mesh of human donor allograft for enhanced soft tissue support. ADM is commonly used for female breast procedures, but in recent years has been applied to other integumentary structures.

Allograft - a graft of skin from a human or cadaver donor.

Autograft - a graft of skin taken from the patient’s own body.

Autologous - from the patient’s own body.

Delay of flap - the use of a mechanism to incise and undermine a flap, but not yet free it, making sure that the small blood supply is adequate for flap survival during neurovascularization.

Donor site - the anatomic site from which healthy skin is taken.

Free skin graft - segments of skin that are completely freed from the donor site before being overlaid on the recipient site.

Full-thickness skin graft - grafts involving two complete layers of skin (all of the epidermis and dermis). This thicker graft minimizes skin contraction and provides increased resistance to trauma and less deformation.

Fusiform incision - a method for removal of subcutaneous lesions with incisions at about a 30-degree angle at both edges.

H-plasty - a technique involving placement of skin flaps in which two single pedicle advancement flaps opposite each other form a pattern in the shape of the letter H when closed.

Island pedicle flap - a pedicle flap consisting of skin and subcutaneous tissue with a pedicle composed of only nutrient vessels (arteries and veins).

M-plasty - a plastic surgery technique for suturing a fusiform incision.

Neurovascular pedicle flap - a pedicle flap consisting of skin and subcutaneous tissue with a pedicle composed of nerves, as well as arteries and veins.

Pedicle - the edge or end of a flap that remains attached to the donor site.

Pinch graft - a graft of skin performed by a small split-thickness repair.

Recipient site - the site on the body to which a healthy skin graft or flap is transferred.

Split-thickness skin graft - grafts that involve two layers of skin; the full epidermis and part of the dermis, and some subcutaneous/fatty tissue, stapled or sewn into place and overlaid with compression dressings firmly wrapped with elastic bandages to provide firm contact.

Tube flap - a bipedicle flap made by elevating a long strip of tissue from its bed except at the extremities, the cut edges subsequently sutured together to form a tube.

Undermining - use of a surgical instrument to separate skin and mucosa from its underlying tissue, so it can be stretched or moved to overlay a defect.

Xenograft - application of a graft of non-human skin or biologic dressing to a defect caused by a traumatic injury, burn, soft tissue infection/necrosis, or surgical wound.

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Finding a Job When You’re Newly Certified

It isn’t easy getting your foot in the door, but putting yourself in someone else’s shoes will help.

Although the economy is maintaining a pulse again and the employment rate of certified coders is at an all-time high, landing that first coding job remains a challenge for many newly-certified coders. Some fledgling coders have been in health care for awhile, performing duties such as checking in patients, assisting providers from a payer’s call center, or calling on claim denials from a billing office. For them, getting the Certified Professional Coder (CPC®) credential was the next logical step in their career; and, the benefits of being certified quickly outweigh the investments of both their time and money.

The same can’t always be said for Certified Professional Coder-Apprentices (CPC-As®) who are only just entering the medical field. Students may spend thousands of dollars preparing for the CPC exam with the unrealistic expectation that certification will guarantee them a job as a coder. This misconception is often the result of false advertising made by disreputable schools.

The reality is that certification does not guarantee employment. It may get your foot in the door and put you in the running, but crossing the finish line is up to you. Are you up for the challenge? To help get you started on the right track, I’ve compiled some of things I’ve learned through personal experience and from tips I’ve read on AAPC’s online forums and career blogs.

Know “Coding” and “Billing” Differences

Coding and billing are terms often used interchangeably, but they are actually two different job descriptions. Know which one you’re applying for before you apply.

Billing, sometimes known as charge entry, is relatively simple and often requires little to no experience to do correctly. Someone else picks the codes and your job is to correctly enter the data into the computer with the appropriate diagnosis code(s) and modifier(s) attached. The majority of medical biller positions available are considered entry level.

Coding is more complex and requires significant training to qualify for employment. Coders either assign codes to provided services themselves or verify the accuracy of the provider’s code selection through medical record documentation review. A thorough knowledge of anatomy and pathophysiology, medical terminology, payer protocol, and coding guidelines is necessary to do this job.

Know What Is Expected of You

A common complaint is that clinics and hospitals require profession-
al certification as well as two or more years (on average) of coding experience before the applicant is eligible for hire.

Even if you attended the most comprehensive training program available, the “A” in the CPC-A credential still stands for “apprentice,” which is just another word for student. You’re still in the early learning phase. You’ve completed the basics, but you’re still green. Health care is a heavily regulated industry and physicians today are faced with an unprecedented level of scrutiny regarding their code selection. Mistakes can be costly and could even place physicians at risk for false claims allegations. Using certified coders is cost effective for physicians since they’re less likely to make simple errors and more likely to capture all billable services in the medical record. But doctors want to make sure coders have experience that can only be gained through real-world coding of medical records—not through multiple-choice answers.

The obvious catch-22 is: It’s difficult to get experience when no one will give you a job. Here’s what you can do:

• **Look to your local chapter to find a mentor or a place to intern.** Internships are generally unpaid positions, but invaluable with respect to the hands-on experience you’ll gain. Alternatively, most AAPC members will graciously offer you assistance, but remember that their time is valuable, too. Even when they don’t require compensation, be courteous, attentive, and don’t take their generosity for granted.

• **Learn from AAPC’s online forums.** Many members with various experience levels use AAPC online forums to ask their most vexing coding questions. This provides you with a broad spectrum of coding dilemmas you might encounter in the real world. Try to answer the questions to the best of your knowledge. When doing this, announce your inexperience and intentions—this will curb any awkwardness if you’re wrong and spur others to check your work. Once you’ve subscribed to a thread, track it to see how others have answered after you. When you’re right, you’ll see affirmation from others; when you’re wrong, you’ll gain valuable insight from experienced coders and learn where you got off track.

**Where to Start Your Job Search**

To get your foot in the door, start with places where your credential is relevant: If you’re a CPC-H, look at hospitals and nursing facilities, for example. For CPCs, outpatient facilities and clinics are a better fit. Either credential will serve you well on the payer side.

Go for any position that will get you working there, regardless of how irrelevant to coding it may seem. Filing, checking in patients, following up on claims, and verifying patient benefits are all great entry-level positions. Tell prospective employers you want to learn as much as possible about the business and you aspire to be a coder. To gain experience, ask if you can shadow a coder in your free time. Always be as enthusiastic about the position you’re applying for as you would be for your dream job. Your work ethic should reflect that enthusiasm if you are hired.

**The Devil Is in the Details**

Whether you’re filling out an application or submitting a resume, attention to detail is crucial. The following points may seem obvious, but applicants frequently neglect to employ these basic principles when applying for jobs:

• Handwritten applications should be neat and legible.

• Use spelling and grammar check functions on your computer for online applications and resumes, but don’t rely solely on them. Always have someone else review your resume and cover letter to catch mistakes you (and your software) might have missed.

• Be polite and friendly to every person (patients, office staff,
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etc.) you encounter over the phone, via email, and in person. They will probably share their opinions of you with others.

- Dress professionally (in business attire) anytime you will be seen, even if only dropping off your application or resume. If you’re unsure of how to dress, err on the side of caution; it’s better to be over-dressed than risk appearing sloppy.

- Highlight previous work experience relevant to the position you’re applying for; every job teaches you skills transferrable to some aspect of your new position—including those in a shoe store or fast food restaurant. Customer service, handling money, and even meticulous cleaning are all job skills that can be useful in a medical office. Don’t be afraid to get creative in listing your qualifications when cataloguing your work experience. Some skills are universally beneficial to employers, regardless of their field.

After this, if you’re still hitting a dead end at every turn, take a closer look at the one common denominator in every unsuccessful attempt: the applicant. Take a moment to honestly review your own attributes and find areas for improvement.

**Take a Good Look at Yourself**

Everyone has room for improvement. It’s difficult to be completely objective because, quite honestly, it hurts. However, good introspection requires objectivity and useful failure-assessment requires quality introspection. See yourself through a stranger’s eyes to get an idea of how you are perceived by others. It may be helpful to enlist a trusted friend or family member to give you constructive feedback. Then, take a detailed accounting of how you’ve performed in past ventures:

- From the moment you entered an office to submit your application or resume, what attitude would you say you conveyed to prospective employers and their staff?
- Were you excited about the potential opportunity and did you greet everyone with a warm, friendly smile?
- Were you nervous and anxious? Maybe you tried to smile, but your heart wasn’t quite in it.
- Did you go into an interview already contemplating failure?

If the last two are true, remember that everyone around you can sense how you truly feel. If you’re pessimistic, anxious, or if you’ve got a chip on your shoulder, those negative emotions will seep out of you in countless ways:

- Facial expressions (even when they’re only fleeting)
- Voice tone (inflection, volume, intonation, and emphasis on certain words)
- Word choices: What you say or don’t say speaks volumes.
- Body language: This will betray you every time. How’s your posture? Do you maintain good eye contact? Do you fidget or are you calm and collected?

To make the most of your face-to-face time with prospective employers, make certain you can always answer “Yes!” to these questions:

- **Do you exude confidence?** If you doubt your own abilities others will, too.
- **Are you happy?** If you are satisfied with your life despite the bumps in the road you’ve had, this independence will reflect favorably on your employer.
- **Are you positive and upbeat?** Employers won’t consider hiring applicants who are negative or who might be detrimental to their staff’s morale when the going gets tough. You’ll spoil your chances from the moment you enter the room if you come off as a negative person.

**Quick Tips to Land You that Job**

Here are a few more tips to keep in mind whenever you meet with a potential employer:

- Hold your head up high and smile at everyone you see, as though you’ve already been given the job. Appear relaxed and comfortable. This is much easier to do if you act like you’ve already succeeded.
- Don’t dwell on past failures; it’s hard to win when you already feel defeated.
- Sell your best qualities to the employer. By playing up the knowledge and experience you DO have, you take focus away from the knowledge and experience you don’t have.

If at first you don’t succeed, try, try again. If you let life’s hurdles get the best of you, you’ll regret it. Get up, dust yourself off, and cross the finish line.

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7 Ways to Save Your Eyes

How we use our eyes has changed more in the last 20 years than it has in the previous 30,000 years: We have gone from using them primarily for distance to spending our time looking at the computer monitors, cell phones, etc., only 10-25 inches in front of us. As a professional coder, you are continuously using your eyes in all aspects of your work. Here are seven quick tips to keep them working for you.

7. Follow the 20/20/20 Rule
Every 20 minutes, take 20 seconds and focus on something 20 feet away from your monitor. This relaxes the eye muscles and keeps them from getting stuck in a super near-vision posture.

6. Adjust Your Computer Screen
Do you know that you can adjust the foreground and background color of your computer monitor? Make sure the contrast between the screen background and the onscreen characters is high, and that you can comfortably see the text and color.

5. Reduce Glare
Glare can cause eye fatigue and headaches. Besides that, it is painful! If you can see your reflection in your monitor, your monitor has glare. Use a glare screen and tilt your monitor away from light sources.

4. Banish Dry Eyes
Here’s the secret: BLINK! People using computers typically blink less often, so their eyes are not lubricated and not being protected.

3. Take a Break
Move away from the monitor, even if it is just for a few seconds. Those precious seconds can make a big difference.

2. Wear Eye Protection
Most of us think eye protection means those large goggles you wear when you go into a production area, but these days it can mean very light, comfortable, and stylish eyewear that looks good and feels good to your eyes. Prescription computer glasses are highly recommended.

1. Place Your Monitor Effectively
Where you place your monitor makes a huge difference. Position your monitor approximately at arm’s length, directly in front and aligned with your keyboard. You should be able to view your entire monitor without flexing, bending, or twisting your neck. Make sure the top of the monitor is at or below eye level.

Bonus Tip: Seek Professional Help
If and when you experience eyestrain or other visual discomfort or impairment, seek the services of a trained professional who can assist with diagnostic and effective treatment to maintain your vision health.

By Steve Gray, AOES, COSS

Steve Gray, AOES, COSS, of Innovative Ergonomic Solutions, Inc., has been practicing the science and art of ergonomics for over 18 years. He is a member of the management team at ERGOhealthy, an ergonomics services provider specializing in predicting and preventing work-related injuries and conducting remote-location and on-site ergonomic assessments to help people resolve issues with their work processes and workstation environments.
It’s that time of year again for...

May MAYnia
Spring to your AAPC Local Chapter

Attend your local chapter meeting in May to:

• Earn FREE/low cost CEUs
• Support your local chapter
• Meet other local coders
• Win great prizes

Don’t want to go alone? Great! Take a friend and help your chapter win prizes and national recognition (non-members welcomed too!)

If you’ve never been to a local chapter meeting, May is the perfect time to get out and see what you’ve been missing!

Find your Local Chapter by visiting:
www.aapc.com/MAYNIA
Chapter Leadership:
2012-2013 AAPCCA Board of Directors

AAPC is proud to announce the 2012-2013 AAPC Chapter Association’s (AAPCCA) Board of Directors—a voting board of 16 coders and one AAPC representative. This elected board brings strength and direction to our local chapters and to AAPC’s national office. Two board members represent each region of the country. Here is your regional representation:

**Region 1 – Northeast**

**Claire Bartkewicz, CPC-H**

**Coding Operations Supervisor, Bayshore Community Hospital**

Claire Bartkewicz has worked at Bayshore Community Hospital for more than 25 years, first as a patient registrar in the emergency department, and later in health information management (HIM). She attended her first coding class when CPT® was in its infancy, and went on to earn a CPC-H®. Claire now teaches at a local community college, and manages the revenue cycles of inpatient and outpatient coding and reimbursement. She is co-founder of the annual New Jersey Coding and Billing Conference. In 2011, Claire was the meeting coordinator for the AAPCCA Board of Directors.

Chapter affiliation: Monmouth Ocean, N.J.

Offices held: President, president-elect, member development officer

**Secretary - Susan Edwards, CPC, CEDC**

**Coding Specialist, Copley Hospital**

Susan Edwards began her career in the health industry as a filing clerk at Florida Health Care Plans in Daytona Beach, Fla., moved up to medical records department manager, and cross-trained in transcription. For the past eight years, she’s worked as a medical coder at Copley Hospital in Morrisville, Vt., where she started in the radiology department and has since transferred to the HIM coding department. In 2009, she was Region 1 - Network of the Year. Susan has written presentations on topics that teach both physicians and staff, and she also teaches medical terminology at a local community technical center.

Chapter affiliation: Newport, Vt.

Offices held: President, president-elect, secretary, education officer

**Region 2 – Atlantic**

**Robin Zink, CPC**

**Business Office Manager, Lancaster Orthopedic Group**

Robin Zink has 26 years of experience in health care, working in various capacities within the physician practice and hospital settings. She earned a CPC® in 2003. She helped establish the Lancaster, Pa. chapter, which now has more than 200 members. Robin enjoys mentoring and encouraging other coders, and is especially proud that her entire coding staff has received their CPC®. Her areas of expertise include revenue cycle management, coding, and regulatory compliance.

Chapter affiliation: Lancaster, Pa.

Offices held: President, president-elect

**Roxanne Thames, CPC, CEMC**

**Coding and Compliance Auditor, Heritage Medical Group**

Roxanne Thames has worked in the medical billing and coding field for 20 years. She started her career as a billing office clerk for a nursing home and later worked as a physician biller/coder for a large internal medicine practice in Lemoyne, Pa. She has taught ICD-9 at Harrisburg Area Community College. Roxanne’s areas of expertise are physician billing, coding and provider education, ICD-9 coding, accounts receivable, collections, evaluation and management (E/M) auditing, and appeals process. She received her CPC® in 2005 and her CEMC™
in 2009. Roxanne now works as a compliance auditor for a medical group, is an active member in her local chapter, and enjoys mentoring, networking, and visiting with other local chapters.

Chapter affiliation: York, Pa.
Offices held: President, president-elect

Region 3 – Mid-Atlantic

**Judy A. Wilson, CPC, CPC-H, CPC-P, CPCO, CPC-I, CANPC**

*Business Administrator, Anesthesia Specialists*

Judy Wilson has been an anesthesia medical coder/biller for more than 28 years. For the past 19 years, she has been the business administrator for Anesthesia Specialists, a group of nine cardiac anesthesiologists who practice at Sentara Heart Hospital. Judy started the Virginia Beach chapter and continues to be an active participant. She also teaches the Professional Medical Coding Curriculum (PMCC) at several locations in Tidewater, Va. In 2011, Judy was the treasurer for the AAPCCA Board of Directors. She has presented at several AAPC regional conferences and national conference.

Chapter affiliation: Virginia Beach, Va.
Offices held: President, president-elect, secretary, treasurer, education officer

**Freda Brinson, CPC, CPC-H, CEMC**

*Compliance Auditor, St. Joseph’s/Candler Health System in Savannah, Ga.*

Freda Brinson has 30 years of health care experience in physician practices and hospital settings. As compliance auditor, she monitors the Centers for Medicare & Medicaid Services (CMS) regulations and performs audits across all service lines. She obtained her CPC® in 1996, CPC-H® in 1997, and CEMC™ in 2009. She was the “2008 AAPC Networker of the Year” and chapter president when Savannah was named “2008 AAPC Chapter of the Year.” She has a strong passion for local chapters and the *Local Chapter Handbook* and enjoys helping chapters understand and succeed.

Chapter affiliation: Savannah, Ga.
Offices held: President, education officer

Region 4 – Southeast

**Meeting Coordinator - Melissa Corral, CPC**

*Provider Relations and Contracting Representative, Northeast Georgia Health Partners, LLC; a subsidiary of Northeast Georgia Health System, Inc.*

Melissa Corral has worked for Health Partners, a local preferred provider organization network in Northeast Georgia, since 2003. With a bachelor’s degree from Brenau University in Conflict Resolution and Legal Studies, she began as a provider relations representative. In 2005, Melissa received CPC® certification. An active participant in her local chapter, Melissa has held chapter offices, and assists with audio-visual presentations.

Chapter affiliation: Gainesville, Ga.
Offices held: Education officer, secretary

**Wendy Grant, CPC**

*Accounts Receivable Manager, Health Management Associates*

Wendy Grant began working in the coding arena in 1977. In her role as accounts receivable manager for Health Management Associates (HMA), Wendy analyzes physicians’ coding trends, mentors and teaches coding and business office personnel via webinar presentations, and provides denial analysis and management for HMA’s enterprises in Tennessee, Oklahoma, Missouri, and Washington. In 2011, Wendy was the secretary for the AAPCCA Board of Directors.

Chapter affiliation: Little Rock, Ark.
Offices held: President-elect, education officer
**Region 5 – Southwest**

**Chair – Angela Jordan, CPC**

*Manager of Coding and Compliance, EvolveMD by WHN*

Angela Jordan has more than 20 years experience in health care. Her primary focus is electronic health record (EHR) training, provider education, and documentation audits. Angela received her CPC® in 2000, and is consistently active in her local chapter. She was honored by her peers as “Coder of the Year,” “Educator of the Year,” and “Networker of the Year” by the Kansas City chapter. Angela enjoys mentoring new members, teaching the CPC® review class, visiting neighboring local chapter meetings, and speaking at meetings.

Chapter affiliation: Kansas City, Mo.
Offices held: President, president-elect, education officer

**Amy Bishard, BA, CPC, CPMA, CEMC, RCC**

*Clinical Coding Auditor and Educator, CoxHealth*

Amy Bishard’s career in the health care industry began in 1999, working part-time in a clinic’s business office. After completing college, she pursued a career in medical coding and obtained her CPC®. As a clinical coding auditor and educator at CoxHealth, Amy monitors Medicare regulations and works with recovery audit contractor (RAC) audits. She designs and delivers educational presentations for physicians and coding and billing staff. Amy develops curricular materials for her chapter’s review classes, as well; and she enjoys mentoring new members and networking with other coders.

Chapter affiliation: Springfield, Mo.
Offices held: President, president-elect

**Region 6 – Great Lakes**

**Barbara Fontaine, CPC**

*Business Office Supervisor, Mid County Orthopaedic Surgery and Sports Medicine*

Barbara Fontaine’s 25-plus years in the medical field have taken her from a part-time admissions clerk in a rural Arkansas hospital to coding and billing for a single family practice physician, and then to a multi-physician clinic, which became a multi-practice group in northwest Arkansas. Family drew her to St. Louis, Mo. in 2001 where she joined Mid County Orthopaedic Surgery and Sports Medicine as a surgery coder and business office supervisor. The practice is now part of Signature Health Services, a large multi-specialty organization. At Mid County, Barbara’s focus is keeping up to date on correct coding and billing for her providers, and continuing education of the physicians and staff. Barbara earned her CPC® in 2001 and became an active member of her local chapter, serving on several committees before becoming an officer. In 2008, she was her chapter’s “Coder of the Year” and was subsequently chosen as AAPC’s “2008 Coder of the Year.” Barbara continues to serve on the local chapter advisory board.

Chapter affiliation: St. Louis Professional Coders, St. Louis West Chapter
Offices held: President, education officer

**Vice Chair – Brenda Edwards, CPC, CPMA, CPC-I, CEMC**

*Coding and Compliance Specialist, Kansas Medical Mutual Insurance Company*

Brenda Edwards has been involved in many aspects of coding and billing since entering the profession more than 25 years ago. Her responsibilities at Kansas Medical Mutual Insurance Company include chart auditing, coding and compliance education, and contributing articles to the company’s website and publication. An AAPC-approved PMCC instructor, workshop presenter, and ICD-10 trainer, Brenda is a frequent speaker for local coding chapters in Kansas and Missouri and has presented at AAPC regional conferences. She is co-founder of the northeast Kansas chapter.

Chapter affiliation: Topeka, Kan. (Northeast)
Offices held: President, president-elect, treasurer, secretary, education officer
**Region 7 – Mountain/Plains**

**Treasurer - Donna Nugteren, CPC, CEMC**  
*Manager of Billing and Revenue Cycle Services, Avera Medical Group Clinic*

With more than 25 years of experience in the health care field, Donna Nugteren has worked in many specialty clinics, hospital systems, and billing agencies. She also has an accounting degree with experience as a business manager. Donna serves on the Corporate Compliance Committee for Avera Hospital and Health Systems and has served on the Service Excellence Committee. For five years, she taught and coordinated local review classes in her area. She has served as treasurer for the past three years in her local chapter and assists with their bi-annual coding seminars.

Chapter affiliation: Sioux Falls, S.D.
Offices held: Treasurer, education officer

**Kathy Burke, CPC**  
*Provider Account Supervisor, HealthCare Billing Resources, LLC*

Active in the field for more than 10 years, Kathy Burke was the first CPC® for HealthCare Billing Resources, LLC medical billing service. Although her primary account is an infectious disease practice, Kathy is a resource for staff and clients on such topics as billing and coding for internal medicine, outpatient mental health, neonatal pediatrics, radiology, and technology-related matters like the 5010 and ICD-10 transitions.

Chapter affiliation: Tucson, Ariz.
Offices held: Education officer

**Region 8 – West**

**Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC**  
*Coding and Billing Manager, Travis C. Holcombe, MD*

Susan Ward started her career more than 20 years ago in billing and has since evolved into coding and management. She is also an AAPC workshop presenter and AAPC ICD-10 trainer. Susan served on the AAPC National Advisory Board (NAB) from 2007-2009. Her enthusiasm for coding and networking shines when you meet her; she is a “cheerleader” for AAPC, and attends chapter meetings while traveling. Susan is the 2012 president of the West Valley Glendale chapter and has held offices with the Phoenix chapter, as well.

Chapter affiliation: Glendale, Ariz.
Offices held: President, president-elect, treasurer, education officer

**Erin Andersen, CPC, CHC**  
*Compliance Specialist, Oregon Health & Science University*

Erin Anderson has worked in coding and compliance since 2003—performing chart audits and educating providers, coders, and staff on coding and billing. Erin seizes any opportunity to expand her coding knowledge and is an active member of the Rose City chapter in Portland, Ore.

Chapter affiliation: Portland, Ore.
Offices held: President, president-elect, education officer

**AAPC Representative**

**Marti G. Johnson**  
*Director of Local Chapter Support, AAPC*

Since 1994, when Marti Johnson joined AAPC, the number of chapters has grown from 30 to just under 500. All of her tenure has been dedicated to the establishment and support of AAPC members and local chapters.
newly credentialed members

Barbara Murphy, CPC
Dellborah Perry, CPC
Abelardo N Sanchez, CPC, CIRCC
Alvaro Mendoza, CPC
Ayes Day, CPC
Akanoria Gupta, CPC
Athea Martin, CPC
Alexandra Walker, CPC
Alexandra Prabhu, CPC
Alisa Richards, CPC
Alan B Corte, CPC
Allison Smith, CPC
Allicia Wiemer, CPC
Barron Allan, CPC
Amanda Alena, CPC
Amanda Natasha, CPC
Amanda Suzanne Taylor, CPC
Amanda Susan, CPC
Amber Ramsey, CPC
Amy Doughtmann, CPC
Angela Lynn Jordan, CPC
Angelica Reyes, MA, BC-H, CPC
Angela Smith, CPC
Angela Tarisa Marshall, CPC
Andi Kumar Kothavale, CPC
Ann Maria, CPC
Ann Marie Foreman, CPC
Anne Heiman, CPC
Annette Cazaux, CPC
Annette Hodge, CPC
Annette Yonne Franklin, CPC
Andrea Marshall, CPC
April Harris, CPC
April Deane Simner, CPC
April Lydie, CPC
Asta Hendriks, CPC
Atamuruk Ramadass, CPC-H
Avi Kumar Sethuraman, CPC
Azza Shaf, CPC
Ashwani Sharma, CPC
Aziz Ferar, CPC
Bair Durr, CPC
Barbara Grant, CPC-H
Barbara Miznikow, CPC
Bemaedine Imry Smith, CPC
Beth A, CPC-H, BC-H
Brooke Roberts, CPC-H, BC-H
Beverly Daughtery, CPC-H
Blanca M Lockhart, CPC
Blonde Jo Sparkes, CPC
Branden Wilson, CPC
Brandon Lynne Mitchell, CPC
Brie Blackwell, CPC
Brigitte Andrew Rosenberg, CPC
Briana J Alvarez-Hatfield, CPC
Camilla Bennett, CPC
Candice Elizabeth Lewis, CPC
Carmel Quiles, CPC
Carlos A Elia, CPC
Catherine Annette Huber, CPC
Cathy Garbolio, CPC
Cathy Wexler-Cannizaro, CPC
Cherie Johnson, CPC
Chasidy Brahams, CPC
Cheryl Franci, CPC
Chow W Melcon, CPC
Chorla Silvain, CPC
Christina F Thompson, CPC-H
Christina Hand, CPC
Christina Willard, CPC-H
Christine Adrian, CPC
Christine Michelle Taylor, CPC
 Chris Fleming, CPC
Claire J Ayres, CPC
Claudia France, CPC
Cody Youmans, CPC
Connie Lynn Nae, CPC
Crystal Finkel, CPC
Crystal Tremblay, CPC
Cynthia Williams, CPC
Cynthia Renee Thompson, CPC
Cynthia East, CPC
Cynthia Mares, CPC
Danielle R Norwood, CPC
Danielle M Harte, CPC
Danielle Marie Munro, CPC
David A Theriault, CPC
David M Donathan, CPC
Debra Counts, CPC
Deborah Garza, CPC
Deborah Garza, CPC
Deborah Jean Olson, CPC
Deborah Jo Hager, CPC
Debra Tisch, CPC
Deidre Males, CPC
Denise Joan Garlick, CPC
Devin Black, CPC
Dhaneswaran Sinhakumar, CPC-P, CPC
Diane Auger, CPC
Diane Bell
Diane Elizabeth Sanders, CPC
Diane Marie Costa, CPC-H
Diane S Anderman, CPC
Dominga Mendez Velez, CPC
Donna L Shirley, CPC
Donna M McCarron, CPC-H
Dorothy Keane, CPC
Eileen Fichter, CPC
Elisa Purnaz Asefa, CPC
Elisa Delmano Marquello, CPC
Emily Conforto, CPC
Emily Lay, CPC
Emily Rose Anderson, CPC
Erenda Cazada, CPC
Evelyn Nicce-Scottard, CPC
Edelina De La Torre, CPC
Evelyn Gittinger, CPC
Evilene E Saldana, CPC-H
Fabiola Shmale, CPC
Fayaya Place, CPC
Francis Shettel, CPC
G L Trout, CPC
Gail Nicholas, CPC
Gangadharan Moulikpal, CPC
Gary Romness, CPC
Germine Ramadan, CPC
Gina Anne Elphinston, CPC
Gina Ivanovic, CPC
Glade Johnson, CPC
Glenda Johnson, CPC-H
Gregory Curti, CPC
Gwendolyn Yumi Sek国土, CPC
Haley Anthony, CPC
Hana Kopp, CPC
Heather Brown, CPC
Hilchik Krotovina, CPC
Hollie D Edwards, CPC
Irene A Dobos, CPC
Isa-A Tadevos, CPC
Jamaela L Holm
Jaroon M Fischman, CPC-H
Jeanette M Marler, CPC
Jeanine Marie Martins, CPC
Jennifer Barbara, CPC
Jennifer Caze, CPC
Jennifer Kari D
Jennifer Lee Day, CPC
Jennifer Lynn Linder, CPC-H
Jennifer Pratszelov, CPC
Jenny Valdez, CPC
Jim Pisg-Shostak, CPC
Jessica Dawn Brown, CPC
Jessica Lynn Rezau, CPC
Jessica R Randall, CPC
Jewel D Dolla Henne, CPC
Joan Pullman-Shabazzab, CPC
Jill Stedka, CPC-H
Jillian Nuoy, CPC
Jodi Lynn Averill, CPC-H
Jody Lynn Jacobs, CPC
John E, CPC
John Kohnke, CPC
John Richard, CPC
John W Maltz, CPC
John W Moore, CPC
Jonay Reicher, CPC
Jonna Marie Cacino, CPC
Joseph Anderson, CPC
Joy Michelle Tull, CPC
Joy Robidule, CPC
Judith A Gallman, CPC
Julie D Roed, CPC
Julie M Sanches, CPC
Julie O Ayres, CPC
Julie Ann Kuhl, CPC
Julie A Yada, CPC
Kaffin Payne Tyler, CPC
Karen Anne Desmon, CPC
Karen O Kurz, CPC
Karen Quint, CPC
Karen L Turner, CPC
Karen Rochelle Bick, CPC
Karen Vennasce, CPC
Katrina Cockschen, CPC
Kathleen Binsb, CPC
Kathleen Kelly Vera, CPC
Kathi Lynn Glaas, CPC
Kathleen A Newson, CPC
Kerith Fiya Frails, CPC
Kelly Ann Neil, CPC
Kelly A Girard, CPC
Kelly Denise Martin, CPC
Kelly Lynn Kib, CPC
Kelly Mittelstadt, CPC
Ken Dreier, CPC
Kelsey Callies, CPC
Kendra Carol Stewar, CPC
Kerry Coster, CPC
Kim Lungsikala, CPC
Kim Renee But, CPC
Kimberly A Barnes, CPC
Kimberly A Slabough, CPC
Kimberly Darby, CPC
Kimbra Michael, CPC
Konstantin Starckesch, CPC
Krisa Marie Jackson, CPC
Krisli Spitz, CPC
Krisi Andre, CPC
Krisi Ann Owens, CPC
Kynama T Brown, CPC
Lamanda Nelson Alston, CPC-H
LaBach Johnson, CPC
Laura Joanne Sassenholtz, CPC
Laura M Turpin, CPC
Laura Shadrake, CPC
Lavina Rascon, CPC
dlessa Wilbych, CPC
Leslee Sweeney, CPC
Lilla H Helmer, CPC
Lisa A Giguere, CPC
Lisa Verkuyl, CPC
Lori L Hovelt, CPC
Lori Presco, CPC
Lorraine K Clark, CPC
Lorraine Taylor, CPC
LouAnn Palmes, CPC
Lourdes Caballero, CPC
Lovel D Dolla Henne, CPC
Lynne Fairhurst, CPC
Lyn T Perez, CPC
Melody Fulcher, CPC
Merri Grund, CPC
Manuel Nalle Perez, CPC
Margaret M Farnen, CPC
Mark Lean, CPC
Marka LaPort, CPC
Marla Salaman, CPC
Marie Camino Reyes Perkins, CPC
Mary Davidson, CPC
Mary Hirmers, CPC
Mary A Wilhemus, CPC
Mary C Sobin, CPC
Mary E Monahan, CPC
Mary F Beamon, CPC-H
Mary K Blair, CPC
Mary Molfett, CPC
Marvin Lewis, CPC
Mayra Hernandez, CPC
Meagan Lynn Diamontes, CPC
Meaghan Blair McIneny, CPC
Megan Good, CPC
Megan Getz, CPC
Melanie Varon, CPC
Melinda I Schult, CPC
Melissa P Robinson, CPC
Melissa Maker McMawson, CPC-H
Melody B Bradford, CPC
Meredith Ressa, CPC
Meredith Miller, CPC
Melissa McCallum, CPC
Melissa Renee Lee, CPC
Melissa Szewcz, CPC
Miroslava Trizna, CPC
Molly Powers, CPC
Molly Sabalin, CPC
Mohammed Hazoq Khan, CPC
Mohit Kumar Krise, CPC
Monika Karolina Bury, CPC
Myrna Sakadar Francisco, CPC
Myriolce Stephanie Chohan, CPC
Nancy JoAnn Monroe, CPC
Natalya Benton, CPC-H
Natasha Ragozes Holcomb, CPC
Nathalie Cormier, CPC
Nicola Navona, CPC
Nicole Edwards, CPC
Nicole Hardwicke, CPC
Nicole M Berry, CPC
Nicole Wyn, CPC
Nino veStefanina, CPC
Odila C Gullerio, CPC
Olaf Faaskorn, CPC, CPC-H
Olivia Thaler, CPC
Padmina Bath, CPC
Pamela Marla Fuentes, CPC
Patricia A Sullivan, CPC
Patricia Ann Cortina, CPC
Patricia Aalmor, CPC
Patricia Kathleen Gwin, CPC
Patricia Lynn Fethen, CPC
Patricia Marie Brown, CPC
Patricia Messiaca, CPC
Patricia Welsch, CPC
Penzhelle Tiaton, CPC
Peter Booko, CPC
Phoebusa Maria Winnow, CPC
Pholokwane Mphahleleni, CPC
Prabhaharan Chandrasankar, CPC
Pradip Deney Nickson Prabu, CPC
Prina Avir, CPC
Pruke Kanya, CPC
Raushan Kumar, CPC
Rebecca A Fotherly, CPC
Rebecca Leopold, CPC
Rebecca Ogle, CPC
Regina A Abat, CPC
Remics Mejiasánchez, CPC
Renato S Ramos, CPC
Rhonda Adams, CPC
Rhonda C Leary, CPC
Robin Miller, CPC
Ronda D Cook, CPC
Rose Holcomb, CPC
Rosetta Thomas, CPC
Rose Garcia, CPC
Samantha Angela Hooye, CPC
Samantha Smith, CPC
Samuel Caballero, CPC
Samuel Rahm, CPC
Sara Abee, CPC
Sanda Radojevic, CPC
Sandra M Hill, CPC
Sandra Tadeo, CPC
Sandy Cox, CPC
Sarah J Hayes, CPC
Sarat Kumar Kendala, CPC
Sathi Saunders, CPC
Shamal Som, CPC
Shapshinda Montana Taylor, CPC
Sharon Bowdalo, CPC
Shan Louen Norman, CPC
Sharon Lorraine Butler, CPC
Sharon D Ogden-Jones, CPC
Sharon Fausta Armstrong, CPC
Shelby Ann Freise, CPC
Shenika LaShawn Bungard, CPC
Shereen Taylor, CPC
Shiru Braghetta, CPC
Sherry Nell Ochoa, CPC
Sherry Soren Ball, CPC
Shirley A Winters, CPC
Shirley Ur, CPC
Sirisha Veramachaneni, CPC
Srija Peri, CPC
Saron Demtra, CPC
Srinivas Mozhavarapu, CPC
Stacey Rivera, CPC-H
Stacy Zelick, CPC
Stefano Lagonara, CPC
Stephanie Gall Buettick, CPC
Stephanie McKey, CPC
Stephanie Oliver, CPC
Stephen D Pearsall, CPC
Steven Page, CPC
Subha R Prasad, CPC
Surat Sharma, CPC
Susan A Hawkins, CPC
Susan M Capecelli, CPC
Susan Springle, CPC
Suzanne Wienczek, CPC
Suzanne Garcia, CPC
Sylva Rime Valentin, CPC
Tamara Metall, CPC
Tammy Curzio, CPC
Tammy Harwood, CPC
Tanu Maudlin, CPC
Teerima Sritain, CPC
Terry Ann Pizzicara, CPC
Thuy Thi Hoang, CPC
Newly Credentialed Members

Apprentices
Aaron Albritton, CPC-H-A
Adrielle Lopez, CPC-A
Adriana Lee, CPC-A
Aja Marchese Adkiss, CPC-A
Alice Anderson, CPC-A
Alice Frago, CPC-A
Alice Rother, CPC-A
Alice Spears, CPC-A
Allison Clark, CPC-A
Alexandra King, CPC-A
Alex Muzzy, CPC-A
Allison Brown, CPC-A
Alison Gagnon, CPC-A
Allison Parnish, CPC-A
Amanda J. Morrell, CPC-A
Amanda Jean Caleo, CPC-A
Amanda Maria, CPC-A
Amanda Whitnour, CPC-A
Amandeep Kaur Bhogal, CPC-A
Amber Lynn King, CPC-A
Amber Nicole Wilson, CPC-A
Amber Whitsett, CPC-A
Annie Mayer, CPC-A
Annette Hyatt, CPC-A
Annie McGuire, CPC-A
Annie Mary, CPC-A
Amy Beare, CPC-A
Amy Cahn, CPC-A
Amy Janssens, CPC-A
Amy L. Bishop, CPC-A
Amy Mussettman, CPC-A
Amy Pflaum, CPC-A
Amy Puchhofer, CPC-A
Amy Rice, CPC-A
Amy Terence Porter, CPC-A
Amy Turner, CPC-A
An M. R, CPC-A
Andrea Bluemel, CPC-A
Andrea B. Shrestha, CPC-A
Andrea Nicole Johnson, CPC-A
Andrea Pastor, CPC-A
Andrey Grinshla, CPC-A
Angela Boyer, CPC-A
Angela Paradis, CPC-A
Angela Staciak, CPC-A
Angie Kristina, CPC-A
Anna M. Cruz, CPC-A
Anna M. Martin, CPC-A
Anita Patnayak, CPC-A
Annamarie Joseph, CPC-A
Annamarie Poitras, CPC-A
Annette Carista, CPC-A
Annette Marie Orlando, CPC-A
Annette Marie Sostojner, CPC-A
Annette Moore, CPC-A
Anne George, CPC-A
April Dawn Subvers, CPC-A
April Sidles, CPC-A
Arline Grandleman-Armado, CPC-A
Arti Kran Kumar Samvedi, CPC-A
Arun Kumar Muthuramalingam, CPC-A
Arun Kumar Singhap, CPC-A
Ashley Guevara, CPC-A
Ashley Jahn, CPC-A
Ashley McCarty, CPC-A
Ashley Park, CPC-A
Ashley Ramirez, CPC-A
Ashley M. Wilcox, CPC-A
Audrey Baldwin, CPC-A
Aurora A. Alcob, CPC-A
Ayaweshini Kumar, CPC-A
Balmari Shankar Gajjali, CPC-A
Barbara Brunner, CPC-A
Barbara Macmorn, CPC-A
Barbara Taggart, CPC-A
Belinda Ballew Smith, CPC-A
Beth Brown, CPC-A
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Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.

I was dragged into coding kicking and screaming. I worked as a sales representative for a regional laboratory serving physician offices and hospitals. My clients’ staff and prospects asked me things like, “What CPT® code do I use to bill your TSH or strep screen?” I didn’t even know what a CPT® code was, so I researched and made a list of our most frequently ordered tests and the correct codes.

I moved on to work at Blue Cross Blue Shield (BCBS) of Kansas City in the Medicare division as the manager of post-payment utilization review (think audit). I was there during some pretty revolutionary times. Diagnosis coding was in a grace period, but soon became required to submit a claim. I was also there during the transition to the resource-based relative value scale (RBRVS) in 1992. The evaluation and management (E/M) codes underwent some pretty hefty changes; descriptions like brief, limited, intermediate, extended, and comprehensive services had no explanation as to what they meant. Auditing was a challenge.

Because I grew up when the 1995 and 1997 documentation guidelines were released, I took a special interest in E/M coding and developed expertise. Since 2000, I’ve been an independent consultant who audits, provides physician education, and teaches family practice residents. I audit all specialties for E/M codes; and in my chapter, I am known as the E/M coding guru.

What is your involvement with your local AAPC chapter?

I travel extensively (for pleasure) and cannot hold an office in my chapter, so I serve through education: I update the “Certified Coder Prep Course,” with the current ICD-9 and CPT® codes every year. I arrange for instructors to come to meetings and manage registrants and course material. I chair a project that offers three levels of E/M coding to members in four-hour workshops on “Basic E/M Coding,” “Advanced E/M Coding,” and “Auditing E/M Codes.” I also helped develop and maintain a position paper on the gray areas of E/M coding that combines the expertise of 12 coders. And I speak at meetings and annual workshops on topics such as ICD-10.

What AAPC chapter benefits do you like the most?
The biggest benefit for me has been networking and forming lasting relationships with supportive people. I can call on my AAPC friends anytime for emotional support and help. I also appreciate the educational opportunities. My local chapter provides educational opportunities that are such good value for the money. For example, at the annual workshop in October 2011, the registration fee included eight continuing education units (CEUs), a draft ICD-10 book, and an anatomy and physiology book.

What has been your biggest challenge as a coder?

As an auditor, I have to remind myself that there’s so much more to an audit than just the level of service. For example, it’s critical that incident-to requirements are met and the correct provider is billed. Legal issues such as Stark law violations and illegal distribution of income from ancillary services are always challenging. Another challenge is keeping up with the ever-changing regulations in all aspects of coding and billing. The new interpretation of the three-day rule, for example, will be a processing challenge for some of my provider-owned clients.

How is your organization preparing for ICD-10?

In late 2011, we began having a 30-minute presentation on ICD-10 at our morning and evening meetings. We will continue doing that until implementation. In 2012, we have quarterly reviews of anatomy and pathophysiology (A&P) to help code for the specificity inherent in ICD-10. Our annual workshop, which attracted 362 attendees in 2011, focused on ICD-10 and everyone received an ICD-10 draft book and an A&P book. We are hoping Kansas City will be selected as a location for a regional meeting on ICD-10 in 2013.

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

Although it may be too late, I would like to work in several different specialties to learn surgery and procedure coding (for example, cardiology, orthopaedics, and obstetrics/gynecology).

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

I spend my spare time with my husband of 47 years and traveling. We have been to all seven continents and are still going. Our next trip is a 115-day world cruise starting in January 2013. I am excited because we are going to Southern Africa, where I have never been.

I have two beautiful daughters and three grandchildren who are the light of my life. I like to eat, cook, and especially bake. Every Christmas, I make about 10-12 different kinds of cookies and deliver them throughout the season to friends and family. I like trying new foods and new restaurants—most recently, Austrian cuisine.

You’ll rarely see me without a book: It could be an international intrigue or mystery book, or it might be a Sudoku or KenKen puzzle book to help prevent Alzheimer’s. As an auditor, I have to remind myself that there’s so much more to an audit than just the level of service.
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