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I. A. Barot, MD, and
Janelle L. Simpson, CPC

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AAPC CODING edge
August 2010

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Features

On the Cover: *With a good night's sleep, Billing Department Manager Janelle L. Simpson, CPC, is quick to verify proper use of sleep codes while billing the sleep apnea and sleep testing services of I. A. Barot, MD, director of Sleep Labs at Virginia Neurology & Sleep Centers, Chesapeake, Va. Cover photo by Count Riddick (www.riddickphotography.com).*

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Teaching Physician E/M

ZPIC Audits

Serving 95,000 Members – Including You

Serving AAPC Members

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

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

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August 2010

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Evolve with Change

How many of us ended up in the coding industry by chance? Many of you probably were headed on a different career path or in a different direction, and then just happened into coding. That is what happened to me and what has brought me to where I am today.

Look to Past Inspiration to Move Forward

About four years ago, I met Reed Pew at a National Advisory Board (NAB) retreat in Salt Lake City. I was the president-elect of the NAB then and was afforded the pleasure of working with Reed early on. He and I looked at member issues, restructured the NAB, and exchanged advice. To this day, I have never met anyone who learned this industry as quickly as he did. He had a good understanding of the challenges we faced. I am truly amazed at the accomplishments of AAPC under his leadership. He is a very hard act to follow, but I am up to the challenge.

Recently, I looked through old *Coding Edge* magazines (I have every issue since 1997) and came across my first NAB president's article, entitled "New Beginnings." I guess it is time again for us to experience a new beginning. What I said then holds true now, "In time of change we must all stay together, and work together for the success of an organization." Although we may not always agree, we should listen to both sides of any issue and make decisions based on the overall well being of the entire membership.

What Lies Ahead?

I have been asked what my goals and objectives are as AAPC president. Simply put: I plan to continue Reed's vision to move our profession forward in the industry.

Every member must understand that our industry is changing rapidly. With health care reform, electronic health records (EHRs), ICD-10, and most likely more to come, our profession must evolve. A coders' role may change, as well. With the EHR, a coder will most likely play the role of an auditor in the future, reviewing documentation and the medical record before the claim is submitted. Compliance will play a huge role in the industry, and mandatory compliance under health care reform will become a reality. My objective is to ensure coders have readily available opportunities to prepare for future changes. My advice is: Don't think about the job you have today, but the job you want tomorrow.

AAPC Leads the Way

AAPC has become more than a coding organization. We are a strong presence in the health care industry and continue to evolve and expand opportunities and services to members and health care professionals. We will offer more career opportunities, education, and credentialing in many areas of health care including coding, compliance, auditing, practice management, etc., ensuring each individual has an opportunity to succeed in their careers. AAPC is becoming the industry leader in "Credentialing the Business Side of Medicine" and we continue to strive for excellence.

I challenge every member to step up and get involved with AAPC to help make a difference in the industry.

Sincerely,

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

AAPC President and CEO

Reimbursement Management:

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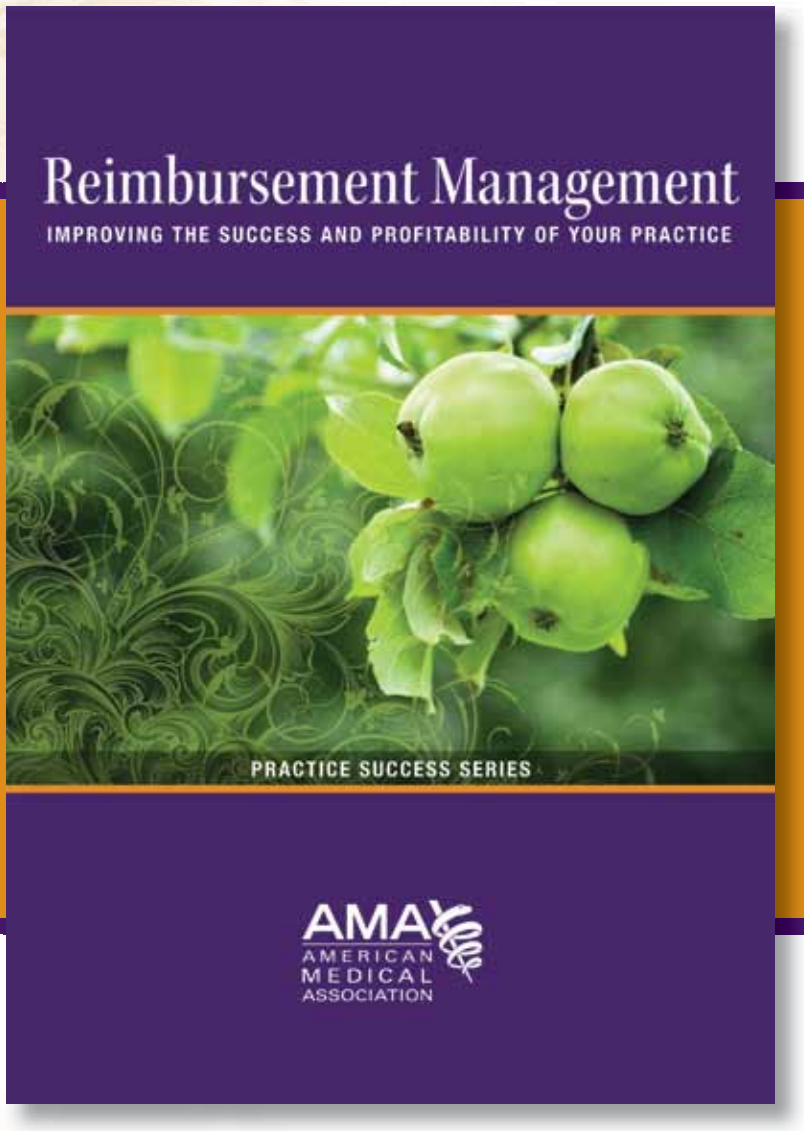

New!

Understanding the coding reimbursement process is vital to today's practice. With the continuous addition of new rules and regulations, the reimbursement process has become more and more complicated.

Newly developed, *Reimbursement Management* will help the medical practice understand the entire reimbursement system and teach the user how to obtain the fullest reimbursement of claims possible, and to avoid allegations of improper claims.

Useful to both the seasoned professional and the newest addition to the medical practice, *Reimbursement Management* will help the user become familiar with the reimbursement process and build confidence when handling reimbursement issues.

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New AAPC Leader Prepared to Take Members into the Future

As you may know, last month there was a change at AAPC headquarters: **Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P**, began her new role as AAPC president. Since her AAPC leadership began, Deborah has received accolades that she deserves wholeheartedly. Her accomplishments as a coder, author, self-employed consultant, and National Advisory Board (NAB) president are impressive. Deborah brings these career accomplishments and coding and business expertise to the everyday decisions AAPC makes.

She's Earned Her Wings

Thinking of Deborah in the context of her career roles, I see her as the coder that launched her career. When she started working in the coding world she didn't see herself as an outstanding leader, NAB president, or consultant; she saw herself as a coder. She was passionate toward her new profession and dedicated to the physicians and coders she worked with. She worked hard, married, and raised a son. Yet, she continued to strive to improve herself and the career she believed in. The accomplishments came because she earned them. Deborah always works hard and continues to care about her fellow coders. As her coding passion grew, so did her accomplishments—and coding excellence has continued to be the backbone of her career decisions and accomplishments.

She's Helped Others Learn to Fly

I had the pleasure of mentoring under Deborah's tutelage as 2007-2009 NAB president-elect. She became president during a time of AAPC transition and I saw her rise to the occasion time and time again. She was there to help Reed Pew move AAPC in the right direction. As NAB president, it will be a pleasure for me to work with Deborah again. The NAB is lucky for the opportunity to work with and know her. The board and I are ready to assist her in any way we can.

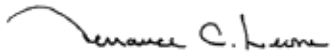
She'll Take Us to New Heights

When Deborah makes a decision for AAPC, that decision comes from the vantage point of coding professionals, AAPC members, educators, auditors, consultants, an NAB president, ICD-10 expert, etc. These many facets of her experience are ideal for AAPC as the future of health care unfolds. Deborah's hard work and devotion to the coding profession will be revealed as she leads AAPC to new heights in our industry.

If asked, however, she would tell each of you that you *too* are capable of reaching the same accomplishments. All it takes is hard work, passion for your career, and dedication to the people you represent.

Congratulations and best wishes to our new president and CEO: Deborah Grider!

Sincerely,



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

coding news

FTC Further Delays Red Flags Rule

The Federal Trade Commission (FTC) May 28 announced it would delay enforcement of the Red Flags Rule for the fifth time, pushing back the compliance deadline from June 1 to Dec. 31.

The latest delay is aimed to give lawmakers time to consider legislation exempting certain small businesses, including physician offices with fewer than 20 employees, from the rule.

The FTC now says physicians should not be included in the Red Flags Rule's definition of a "creditor," but it would take Congressional action to exempt them.

Several medical groups have contended all along that physicians should not be included in the rule, which requires all businesses offering credit to develop and implement written identify theft prevention and detection programs.

Medical groups went so far as to file a lawsuit which seeks to exempt physicians from the rule after news of the American Bar Association (ABA) successfully blocking implementation of the rule for legal offices.

The good news is: The FTC chair said June 25 the agency would not enforce the rule against members of the American Medical Association (AMA), the American Osteopathic Association (AOA), state medical societies, and the Medical Society of the District of Columbia while the Red Flags Rule litigation filed by the ABA is in federal appeals.

FTC was scheduled to answer to the physician group's lawsuit by July 20, but that date was delayed until 60 days after the "re-opening date," when the federal appeals court rules on the ABA case. FTC also has agreed to delay enforcement of the rule for physicians for an additional 90 days after the re-opening date.

The bad news is: While all this sounds like physicians might not have to comply with the Red Flags Rule, your practice's legal council may advise otherwise. "Until the law or the regulations are changed, you are stuck with what they are," said Peter McLaughlin, senior council with Foley & Lardner LLP in Boston. "… We don't know if physicians will be fully exempt or partially exempt. It would be unwise to do nothing."

ICD-9-CM Gets Detailed in 2011

ICD-9-CM changes for 2011, effective Oct. 1, allow for greater diagnostic detail, where a four-digit code is deleted and replaced by two or more, five-digit codes. For example, reporting disorders of iron metabolism, secondary thrombocytopenia, anomalies of the uterus, insertion of intrauterine device encounters, and body mass index (BMI) of 40 and over can now be more specific.

Seven location/system-specific codes to describe personal history of corrected congenital malformations will be added: V13.62-V13.68. Although these new codes allow for specific reporting, if a more precise location/system is unknown or not specified, you can report revised code V13.69 *Personal history of other (corrected) congenital malformations* **only** if no other code better describes it.

Blood Incompatibility Reactions

Codes 999.60-999.63, 999.69, 999.70-999.79, 999.80, and 999.83-999.85 will be added to further describe deleted codes 999.6 *ABO incompatibility reaction* and 999.7 *Rh incompatibility reaction*, as these codes did not distinguish between ABO and non-ABO HTRs, and between acute HTRs and delayed HTRs.

Multiple Gestation

All new among changes for 2011 is the creation of category V91, which allows tracking and reporting of the number of placenta and amniotic sacs for multiple gestation pregnancies.

Ectasia

Codes 447.70-447.73 were created to describe ectasia, a weakening (with some dilation) of the aortic wall.

Military Requests

For 2011, the Department of Defense (DoD) proposed adding V11.4 *Personal history of combat and operational stress reaction*, which provides the capability of tracking patients who later have symptoms related to having had COSR. The DoD also requested new codes for embedded fragment status: V90.01, V90.09, V90.10, V90.11, V90.12, V90.2, V90.31, V90.32, V90.33, V90.39, V90.81, V90.83, and V90.89.

More to Come

For detailed coverage on ICD-9-CM changes for 2011, read next month's *Coding Edge*. The final addendum providing complete information on changes to the diagnosis part of ICD-9-CM is posted in downloadable PDF format on CDC's webpage at: www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm#addenda.

Check for future changes to ICD-9-CM and other code sets as they are released on AAPC website: www.aapc.com.

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

Letters to the Editor

A Different Perspective on HCCs and Health Plan Payment

I appreciated reading the article published in the May 2010 *Coding Edge* on Hierarchical Condition Categories (HCCs) ("Hierarchical Condition Categories Drive Disease Payment," pages 48-49), especially because this seems to be an emerging area of interest with respect to the Medicare Advantage (MA) industry and curious coders. Ms. Smith highlighted many important points of this payment method. I would like to add a slightly different perspective and additional clarification relative to a health plan whose network providers' payments are not directly affected by ICD-9-CM coding.

The type of health plan to which I'm referring issues reimbursement based on either contractual agreements or fee schedules (vs. risk scores). For example, a patient with MA coverage who has controlled diabetes mellitus type 2 (DMII) was seen by her primary care physician (PCP) for treatment of a sore throat, as well as for joint pain in her right shoulder. Her PCP submitted a claim for the appropriate evaluation and management (E/M) service and listed the respective diagnosis codes for the sore throat and joint pain, but did not list the diagnosis code for her DMII. Payment for this E/M service would have been the same, regardless if the DMII was coded.

The Centers for Medicare & Medicaid Services (CMS) issues payment to MA plan sponsors for each of the plan's MA members consistent with the most severe condition(s) per HCC (HCCs are derived by risk adjustment data submitted to CMS). Quality documentation and adherence to the *Official Guidelines for Coding and Reporting* are essential to ensuring proper reimbursement for health plans that operate either by way of contractual agreements/fee schedules or based on risk scores.

Jennifer M. Oravecz, CPC

Essential Hypertension Doesn't Track With HCC

Please accept this as a clarification of the use of hypertension as an example of a chronic health condition for the Centers for Medicare & Medicaid Services (CMS) hierarchical condition category (HCC) model, as described in the *Coding Edge* article "Hierarchical Condition Categories Drive Disease Payment" (May 2010, pages 48-49).

The author writes, "Is your provider assessing all chronic health conditions such as hypertension, chronic kidney disease, depression, etc., at least once a year?" It should be pointed out that relatively few diagnoses of hypertension actually have an HCC code. ICD-9-CM 401.x *Essential hypertension* does not track with HCC, nor do most levels of 402.xx *Hypertensive heart disease* (except when heart failure is involved). Other levels of hypertension can have an HCC code but generally only when heart failure and/or chronic kidney disease are involved.

Diovan, also cited in the article, is a common medication for essential hypertension, but the mention of it in a provider note is not a definite indication that the related diagnosis is the type of hypertension that has an HCC code.

This is one of the interesting challenges of working with Medicare Risk Adjustment. Some conditions such as hypertension or hyperlipidemia do not track with this program, even though they certainly can be considered chronic and an important factor of the patient's overall health status.

George Dansker, MPH, MLIS, CPC-A

Coding Each Additional Immunization Administration

Regarding Sharon Brown's observation in June 2010 "Letters to the Editor:" I agree that immunization and associated administration for a child under age 2 should not be intranasal. However, code 90472 is incorrect (at least as an initial administration) because it is an add-on code not to a substance such as a vaccine or toxoid, but to a first administration; that is, 90472 is used for second and subsequent administrations. Note that CPT® 2010 contains a parenthetical note beneath 90472 that specifies, "Use 90472 in conjunction with 90471 or 90473."

Also: Because the original article in the April 2010 *Coding Edge* ("Don't Let Vaccines Poke Holes in Your Practice's Pockets," pages 20-22) states, "The nurse provided the information sheet and additional discussion specific to the Hib, PCV, and influenza vaccines," this appears to qualify all four immunization (DTaP, Hib, PCV, and flu) administrations for "the physician counsels the patient/family" clause in 90465, and extending to 90466 for the other three immunization. As a result, I believe the proper coding of this sequence to be:

90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use

90465 Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; first injection (single or combination vaccine/toxoid), per day

90645 Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use

90669 Pneumococcal conjugate vaccine, 7 valent, for intramuscular use

90655 Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use

+90466 Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; each additional injection (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure) x 3.

On the other hand, it could be construed that the "additional discussion" on the Hib, PCV, and flu vaccines is incidental, in which case the coding is:

90700

90465

90645

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

90669

90655

+90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) x 2.

To clarify: It's possible that 90472 would be correct to represent the last two vaccine immunizations (PCV and flu), but only after 90471 is used up for the Hib. The real question is, does the "additional discussion specific to" the Hib, PCV, and flu vaccines constitute counseling of the parent, as it does with the wording for the DTaP? If so, you must use the coding in the first example above.

Ken Camilleis, CPC
Superbill Consulting Services
Yarmouthport, MA

Many thanks to Ken, as well as **Sherrie Daigle, CPC,** A/R manager for Health Access Network, Inc., and **Melinda Myers, CPC,** billing manager for Medical Billing Resources, who also wrote to us to clarify this issue. CE

Dive into Discounts

Go on a shopping spree with AAPC.

By Danielle Montgomery

There are many benefits to being a member of AAPC. One of the least known is our affinity program. Admittedly, I knew that the program offered excellent savings on a number of items but didn't know about all of them. For instance, you can get 10 percent off items from Target when shopping online, 15 percent off online orders over $100 through Kohl's, up to 50 percent off certain online items through Office Depot, and 25 percent off an online order of $50 or more through Hot Topic (This one is best used while you're biting your tongue, buying that studded belt and heavy metal CD for teenagers who haven't discovered who they are, yet.).

AAPC member benefits range from discounts on code books to trips to Disneyland. If you think about it, you can save more than the amount of your membership dues per year by taking advantage of the discounts AAPC offers.

Convenient Online Savings

I wanted to see exactly what member benefits we offer, so I decided to poke around online a little. I was surprised by what I found. At www.aapc.com/resources/member-benefits.aspx there are many companies offering discounts on items and services ranging from travel and recreation services to movies and entertainment; jewelry and gifts to office supplies and flowers. All services are offered for online shopping; and, if you're like me, you're busy working long hours, taking kids to piano lessons and baseball practice, running errands as fast as you can before businesses close, and somehow throwing dinner in the mix. Who has time to shop? The convenience of online shopping is something that many of us have come to love.

One section on the Member Savings Benefits webpage that I am thrilled about is the **AAPC Savings Connection**, where you can find an abundance of grocery coupons. There are three things you need to know about me: I have two kids (a bottomless pit of an 8-year-old son and an ever-growing 1-year-old daughter), I'm trying to lose weight (I'm claiming it's still baby weight—a year later), and I'm on a tight budget.

I've never coupon clipped before. I was intrigued, however, by the concept and decided to try it out. While browsing through the coupons AAPC offered, I found a number of things beneficial to my family—and my never ending quest to fit back into my jeans. There were coupons for cereal, yogurt, healthy granola bars, infant formula, diapers, dinner items, dessert items (these were hard to avoid), miscellaneous household items like Combat, Glade Plug-Ins and lotion, frozen vegetables, juice, cleaning supplies, snacks, coffee and many, many others. I printed my selected coupons, cut them out, and sped to the store.

Let's Shop

While shopping, I purposely avoided all in-store coupons to discover exactly how much I could save with just the coupons I printed through the AAPC Savings Connection.

As a picky eater, grocery shopping is normally hard for me because I don't like a lot of things that my son and husband enjoy. I was doubtful I could find anything I liked with the coupons I had; however, I was delighted to find many items I liked and that my son and husband would eat as well. This gave me the motivation to purchase healthier items (again, the "baby weight") that weren't too expensive—plus, the additional savings I received.

Another concern on my list was that the store I went to—an exclusively suburban grocery store right down the street—would not have a lot of the coupon items. I was pleasantly surprised to find most of the items for which I had coupons.

While walking through the grocery store, my cart slowly filled. Excited, I couldn't wait to get to the checkout line to see how much I saved!

I got a workout pushing and navigating the cart through the aisles to the checkout counter. I piled my items on the counter and told the cashier, "You're going to hate

me. I have all of this stuff and a TON of coupons!" Because I'd never clipped coupons before, I didn't know how it worked. The cashier scanned all of my items and then I handed her my stack of coupons. She took them, scanned them one by one, and it was done in 30 seconds. I didn't have to deal with the embarrassment of holding up a line of customers while the cashier begrudgingly entered my coupons in. They were easily printed, cut, and scanned.

Cha-ching!

It was nice to see the total amount due continually shrinking with each coupon scanned. When done, the receipt said I saved $35.45, or 15 percent.

While a savings of 15 percent is excellent, keep in mind that I also had to buy items for which I didn't have coupons because I hadn't been grocery shopping in probably a month and a half. If I'd gone solely for items that I had coupons for, I would have walked away with a pantry full of food with even more savings.

Look to **AAPC's Savings Connection** coupons to bolster the amount of money in your checking account. This combined with in-store coupons and smart shopping will save you even more.

Besides the money I saved, there are four things I learned from this experiment:

1. I'll take advantage of this member benefit again.
2. I'll be sure to organize the large amount of coupons by section to significantly cut down the in-store shopping time.
3. You don't lose 10 pounds by making one trip to the grocery store.
4. I'll make my husband watch the kids every time I grocery shop.

AAPC offers navigation assistance for members looking to take advantage of all benefits available to them. Give us a call at 800-626-2633 and we'll help you "surf the web."

[Danielle Montgomery
is the director of membership at AAPC.]

Jacksonville Conference Sizzles with Success

A last-minute venue change didn't stop coders from four days of major coding and a whole lot of fun in the sun.

By G. J. Verhovshek, MA, CPC

This year's AAPC National Conference took place June 6-9 in sunny Jacksonville, Fla. Approximately 1,850 attendees turned out for the 18th annual conference to enjoy education and networking opportunities, as well as have some fun in the Sunshine State.

The conference kicked off Sunday, June 6, with a "Country Coding Jamboree," a Grand Ole Opry-style hoedown that finally answered the burning question, "Just what *does* AAPC National Advisory Board (NAB) President **Terri Leone, CPC, CPC-P, CPC-I, CIRCC**, look like in chaps?" Leone, the rest of the NAB, and special guests danced and sang their way through a few popular favorites—which had been lyrically adapted to honor the occasion—before turning the stage over to AAPC's Legal Advisory Board.

Legal Side of Coding

Julie E. Chicoine, Esq., RN, CPC; **Timothy Blanchard, JD, MHA, FHFMA**; **Michael Miscoe, Esq., CPC, CASCC, CUC, CHCC, CRA**; **Christopher Parrella, JD, CHC, CPC**; and **Robert Pelaia, Esq., CHC, CPC,** presented a panel discussion of legal trends and issues, including:

- New enforcement provisions in the new health care law and what this means to providers;
- Recent changes to the False Claims Act (FCA) and possible implications for providers and qui tam relators (whistleblowers);
- The mandatory/voluntary repayment of identified overpayments provision in the new health care law; and
- Insights on trends in the Medicare post-payment appeals process, the diminishing likelihood of obtaining an objective review, and the rigid emphasis on documentation content as a basis for coverage determination.

The panel then opened the floor to questions and addressed additional concerns, including coder liability under the FCA for erroneously-coded claims. The lively exchange that followed continued at the front of the auditorium even after the session had ended.

Focus on Local Chapters

As Sunday's activities came to a close, attendees were invited to "Get to Know Your Local Chapter." Local AAPC chapters from around the country put their best foot forward, creating displays to showcase the unique attributes of their groups and hometowns. Three judges voted on their favorite displays, with Best of Show honors going to the Kansas City Local Chapter.

Local chapters also attracted special attention during the pre-conference program: The AAPC Chapter Association (AAPCCA) held three hours of training early on Sunday for local chapter officers or those wishing to become local chapter officers. Breakout sessions were offered for each chapter officer (treasurer, secretary, etc.), and in areas such as leadership skills and dealing with difficult people.

Eat, Shop, and be Merry

Monday morning the doors to the main hall were open for breakfast and a chance to visit with more than 60 exhibitors who offered coding references, software, educational materials, and continuing education opportunities. Exhibitors offered attendees product demonstrations, advice, gifts, and (as usual) a lot of candy.

Following breakfast with the exhibitors, **President and CEO Reed Pew** delivered his annual state-of-the-AAPC address. He remarked on AAPC's continuous strong growth, noting that membership recently passed the 94,000 mark, and is on track to reach the goal of 100,000 members by year's end. He also discussed the state of the health care industry in general, including specifically the necessity to control costs and the probable trend toward more care by mid-level providers. He offered predictions on the impact of the electronic health record (EHR), how the physician's office of the future will differ, and AAPC's role as the business side of medicine evolves.

Farris Jordan, PhD, followed up with a hilarious and insightful keynote speech. By way of his one-of-a-kind, down-home, story-telling talent, Jordan demonstrated that laughter is a great way to reduce stress and reclaim control of your state of mind and the adverse circumstances in which you sometimes find yourself. Refreshed and energized, attendees were set loose to attend the individual educational sessions.

Put on Your Thinking Cap

Session topics during the following three days ran the gamut–from ICD-10, to legal concerns (such as the Red Flags Rule and handling possible identity theft and other privacy violations), to various audits (Recovery Audit Contractors (RACs), Medicaid Integrity Contractors (MICs), Zone Program Integrity Contractors (ZPICs), etc.), to specialized classes for obstetrics and gynecology (OB/GYN), surgery (hand surgery, spinal surgery, and others), primary care, advanced general coding, evaluation and management (E/M), payer "hot button" issues, and much more.

Especially popular June 7-8 was the Anatomy Expo. Eight physicians explained procedures and physiological issues within their areas of expertise, using videos, models, and devices. The expo gave coders a more detailed understanding of the human body to improve attendees' coding accuracy.

Even though the conference was moved as a result of Nashville's disaster, Music City wasn't forgotten. (Photo by Jerry Godolphin)

Attendees flocked to the legal roundtable. (Photo by Jerry Godolphin)

Many felt the presentations represented the professional level of the members. (Photo by Jerry Godolphin)

Following breakfast, June 8, **Deborah Grider, CPC, CPC-H, CPC-P, CPMA, CPC-I, CIMC, COBGC, CPCD, CCS-P,** gave the general address, discussing the importance of preparing now for ICD-10 implementation. As Grider noted, 2013 isn't as far away as it seems, especially considering all that must be done to transition to ICD-10 smoothly. If your systems aren't operational and tested in advance of the mandatory implementation date, cash flow within your practice or facility likely will come to a deadly halt.

Coders Who Personify Excellence

At the Member Appreciation Luncheon, June 8, **Nancy Higgins, CPC, CIRCC, CPMA, CPC-I, CEMC,** of Charlotte, N.C., was recognized as the 2009 Coder of the Year based on her outstanding performance as a coder and her involvement in educational efforts for her fellow coders. **Lori Hendrix, CPC, CPC-H, CIRCC, CPC-I,** of Dallas, Ga., was presented with her second Networker of the Year award due to her extensive involvement in her local chapter and the coding community. The 2009 Chapter of the Year award was given to the Chapel Hill, N.C. Local Chapter, for going out of their way to make all members feel welcome.

As the Conference Winds Down ...

The final day, June 9, began as usual, with breakfast with the exhibitors. **Patricia Raymond, MD, FACP, FACG,** followed with a keynote address, "Rx for Sanity: Triage, Love, & Laughter."

At the mid-day lunch and general session, Pew announced he would be stepping down as AAPC president as of July 1 to take on other assignments within the company. Pew was

recognized by AAPC staff for making AAPC the professional organization we have become under his tenure. As reported in last month's *Coding Edge* (July 2010, pages 12-13), Grider will bring her considerable knowledge and experience to her role as AAPC president.

Nashville Flood Relief Strives for Recovery

In a heartfelt gesture, AAPCCA Chair **Jill Young, CPC, CEDC, CIMC,** presented a check for $10,600 to the American Red Cross for the relief efforts in Nashville, Tenn. following the severe flooding there in early May. By the end of the conference, local chapters had raised nearly $12,000 for the relief effort, easily exceeding their $10,000 goal.

The floods that hit Nashville so hard required a last-minute conference venue change. The AAPC Conference Team ensured everything ran as originally planned and Jacksonville stepped up to the plate and welcomed AAPC and its members with open arms. The city supplied buses to transport attendees to and from the convention site, and provided signs, extra services, and helpful city guides to make everyone feel welcome. Attendees took advantage of the hospitality, and many were seen spending their evenings eating, drinking, dancing, and laughing at the Jacksonville Landing, or visiting the beautiful local beaches or nearby St. Augustine.

Attendees mill around at the Get to Know Your Local Chapters event. (Photo by Jerry Godolphin)

For more about the Jacksonville conference, check out the Biscuit Report at www.aapc.com/medical-coding-education/conferences/national/nashville/index.aspx.

The next National Conference will be held in Long Beach, Calif., April 2-6, 2011.

G. John Verhovshek, MA, CPC, is director of editorial development/managing editor at AAPC.

Documentation Causes Debridement Dilemma

Get your physicians to document correctly or leave money on the table.

By Holly J. Cassano, CPC

To be descriptive enough to create a clear picture of the procedure performed, debridement documentation in the outpatient setting must describe:

Method of debridement—The most common methods include:

- Wet-to-dry dressings. Wet dressings are applied to the wound and allowed to dry. When the dry dressing is removed, it pulls off the dead tissue.
- Application of medications that contain enzymes to dissolve dead tissue.
- Application of medicated dressings.
- Whirlpool baths.
- Surgical debridement with scalpel or scissors to remove dead tissue (*the focus of this article*).

CPT® section notes, "Removal of Infected/Devitalized Tissue—(11040-11044)," describes surgical debridement as:

"The physician surgically removes necrotic or dead skin. The physician uses a scalpel or dermatome to remove a superficial layer of affected skin. The epidermal layer is removed with the underlying dermis remaining intact. The partial thickness of skin is excised until viable, bleeding tissue is encountered. A topical antibiotic is placed on the wound. A gauze dressing or an occlusive dressing may be placed over the surgical site."

Depth of debridement—Did the provider debride beyond the dead or damaged tissue down to healthy, viable tissue?

Whether the debridement was excisional or non-excisional:

- Excisional debridement—Cutting away necrotic, devitalized tissue or slough to the level of viable tissue using a sharp instrument (i.e., scalpel, scissors, etc.).
- Non-excisional debridement—The removal of necrotic, devitalized tissue or slough by means of scraping, mechanical brushing, flushing, or washing (i.e., irrigation; whirlpool); minor removal of loose fragments.

Instrumentation—Did the health care provider use a scalpel or scissors? Use of a scalpel or blade is a better indication an excisional debridement was performed. Scissors may be used

to cut away loose fragments, which is not indicative of excisional debridement. Code assignment cannot be based solely on the instrumentation, but instrumentation does assist in describing how the debridement was done.

Always remember that if the documentation is unclear, you must to query the physician for clarification.

Separate Services May Be Coded Separately

By CPT® rules, debridement excludes:

- Burn debridement or treatment (16000-16035)
- Dermabrasions (15780-15783)
- Nail debridement (11720-11721)

You may report separately any of these excluded services.

Individual payers may offer more specific instruction about what's excluded from debridement. For example, the following is from First Coast Services Options, Inc. (FCSO) Medicare (www.cms.gov/MCD/viewlcd.asp?lcd_id=29128&lcd_version=6&show=all):

"FCSO does not consider the following services to be wound debridement:

- Removal of necrotic tissue by cleansing, scraping (other than by a scalpel or a curette), chemical application, and wet-to-dry dressing.
- Washing bacterial or fungal debris from lesions.
- Removal of secretions and coagulation serum from normal skin surrounding an ulcer.
- Dressing of small or superficial lesions.
- Removal of fibrinous material from the margin of an ulcer.
- Paring or cutting of corns or non-plantar calluses. Skin breakdown under a dorsal corn that begins to heal when the corn is removed and shoe pressure eliminated is not considered an ulcer and does not require debridement unless there is extension into the subcutaneous tissue.
- Incision and drainage of abscess including paronychia, trimming or debridement of mycotic nails, avulsion of nail plates, acne surgery, or destruction of warts. Providers should report these procedures, when they represent covered, reasonable and necessary services, using appropriate CPT® or HCPCS codes."

Check with your individual payer(s) for any specific debridement coding requirements it may stipulate.

Know Your Surgical Debridement Codes

Surgical wound debridement procedures are coded primarily in outpatient settings, utilizing CPT® codes 11040-11044. The code(s) reported will depend on the type(s) of tissue debrided, as follows:

11040 Debridement; skin, partial thickness

Nonfacility relative value units (RVUs): Work RVU: 0.5000; PE RVU: 0.6500; Malpractice RVU: 0.0300;

Total RVU: 1.1800

11041 Debridement; skin, full thickness

Nonfacility RVUs: Work RVU: 0.6000; PE RVU: 0.7200; Malpractice RVU: 0.0400;

Total RVU: 1.3600

11042 Debridement; skin, and subcutaneous tissue

Nonfacility RVUs: Work RVU: 0.8000; PE RVU: 0.9900; Malpractice RVU: 0.0700;

Total RVU: 1.8600

11043 Debridement; skin, subcutaneous tissue, and muscle

Nonfacility RVUs: Work RVU: 3.1400; PE RVU: 3.6500; Malpractice RVU: 0.3700;

Total RVU: 7.1600

11044 Debridement; skin, subcutaneous tissue, muscle, and bone

Nonfacility RVUs: Work RVU: 4.2600; PE RVU: 5.0500; Malpractice RVU: 0.5400;

Total RVU: 9.8500

All aforementioned RVUs are based on a conversion factor of 36.0791. This means, for instance, the total national average Medicare payment for the most extensive debridement, 11044, would be $355.38 (9.85 x 36.0791), verses $42.58 (1.18 x 36.0791) for the least extensive debridement, 11040. The reimbursement difference underscores the financial importance of coding these procedures correctly.

Tip: Always document the total area (cm or sq cm) of each site/wound per procedure to ensure reimbursement for the code level best reflecting the service performed. Although codes 11040-11044 do not account for area, indicating the size gives the carrier (if notes are requested or in the event of an audit) additional information about the work involved.

Not Every Service May Be Reported Independently

Active wound care codes 97597-97606 are for removing devitalized and/or necrotic tissue from wounds to promote healing, only when treating the surface skin of a wound, and are not billed in addition to debridement (11040-11044). Codes 97597-97606 generally are reported by non-physicians for selective and nonselective debridement procedures.

Remember also skin debridement that is preparatory to further surgery should not be coded as a separate procedure when debridement of an open fracture site is performed. Skin debridement is considered inherent for this procedure.

Consider the following coding example: A 75-year-old patient with type II uncontrolled diabetes presents to the emergency department (ED) with diabetes with peripheral circulatory disorders. During the exam, the ED physician discovers cellulitis of the right lower leg with small areas of necrotic tissue surrounding several wounds measuring 4 cm in total. The physician decides to perform a partial thickness debridement of and around the infected tissue with a scalpel. He measures the total area after the procedure and indicates the wound is now 5.5 cm, applies a topical antibiotic and a dressing, and orders a course of high-dose IV antibiotics to start in the ED.

You would report:

99284-25 Emergency department visit for the evaluation and management of a patient, which requires 3 key components; A detailed history; A detailed examination; and Medical decision making of moderate complexity. -Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service

682.6 Other cellulitus and abscess; leg, except foot

250.72 Diabetes with peripheral circulatory disorders

443.81 Peripheral angiopathy in diseases classified elsewhere

11040

682.6

250.72

443.81

Billing Multiple Debridements

CPT® guidelines do not restrict the number of times debridement codes can be reported for a course of treatment; therefore, 11040-11044 may be used more than one time in a single patient encounter for debridement of multiple sites (wounds). The appropriate code is selected for each site depending on the type of debridement performed, and modifier 59 *Distinct procedural service* is appended to the secondary (and tertiary, if applicable) code.

When billing multiple site/wound debridements, document each site/wound. Medicare only pays for up to five debridements before requiring medical records to be submitted to substantiate medical necessity for each.

For example: A 40-year-old male who was riding a mountain bike falls and suffers multiple wounds on his forehead, arms, and legs, with a lot of foreign material in the wounds. He presents to the ED and after assessment the ED physician performs excisional debridement of the wounds to prevent infection. There is a 5 cm open wound to the right hip/thigh area that goes to the muscle, a 4 cm open wound to the left calf that goes to the muscle, a 4 cm open wound to the right bicep, and a 2 cm wound to the forehead. The ED physician debrides the right bicep and the forehead wound, and then oversees a plastics fellow debride the hip and the calf.

Code as follows:

99284-25

890.1 Open wound of hip and thigh, complicated

E826.1 Pedal cycle accident injuring pedal cyclist

E849.4 Place for recreation and sport

11043-GC Teaching physician was present during the key portion of the service and was immediately available during other parts of the service

890.1

E826.1

E849.4

11043-59-GC Distinct procedural service

891.1 Open wound of knee, leg [except thigh], and ankle, complicated

E826.1

E849.4

11042-59

880.13 Open wound of shoulder and upper arm, complicated, upper arm

E826.1

E849.4

11040-59

873.52 Other open wound of forehead, complicated

E826.1

E849.4

Watch for Global Periods

Global periods for debridements vary according to depth:

- The global period for 11040, 11041, and 11042 is zero.
- The global period for 11043 and 11044 is 10 days—meaning that all the pre-service, intra-service, and post-service work (up to 10 days for 11043-44) and cost to provide the service are included in the code.

For example: A 25-year-old female trips and falls on the street and is treated in the ED five days prior. The ED physician performs a partial thickness debridement of her cheek (complicated), packs the wound, prescribes a course of antibiotics, discharges her home, and tells her to return in five days for a recheck. At the time of service, coding is:

99283-25 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and medical decision making of moderate complexity

873.51 Other open wound of cheek, complicated

E885.9 Slip and fall, unspecified

E849.5 Place of occurrence, street

11040

873.51

E885.9

E849.5

The patient returns to the ED for follow-up care. After an assessment on the fifth day, the ED physician cleans the wound, dresses it again, and continues the patient's current course of antibiotics. Because 11040 has a global period of zero, the visit may be reported with:

99281 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components; A problem focused history; A problem focused examination; and Straightforward medical decision making

873.51

V58.31 Encounter for change or removal of surgical wound dressing

E885.9

E849.5

Holly Cassano, CPC, has been involved in practice management, coding, auditing, teaching, and consulting for multiple specialties for the past 13 years. She served two terms as an AAPC local chapter officer, has written several articles for Justcoding.com and has a monthly column on fighting fraud with *Advance for Health Information Professionals*. She is the coder and physician educator for emergency room physicians at the Cleveland Clinic Florida. You can reach her at hjcpmg@yahoo.com.

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Seven Details to Check Before You File

By Beth Morgan, CPC, MCS-P

Proofing claims prior to submission prevents time-consuming denials later.

APPRENTICE

It never hurts to double-check claims for accuracy before you transmit them. The extra step may save you or your customer service department from having to deal with a denial later. Here are seven common problem areas to consider:

1. Do you have the right patient? I personally have witnessed registrars confusing one patient for another because two patients had the same or a similar name. Don't select automatically the first name that looks like a match: Check addresses and dates of birth to verify you are billing the correct individual.

2. Have you charged for the correct tests, procedures/services that were given or received? For instance, did the physician/provider order one test, but you charged for two? Entering a bill for services/procedures takes concentration, and data entry errors could result in a patient being charged more than once for the same service, supply, or medication. Review the charge slip to verify how many tests were ordered on the day in question.

3. Are the hospital days, rooms, and services billed accurate? An inpatient hospital stay charge should be from the admission date until the discharge date only. For outpatients, charges should be for the actual department in which the patient was seen. For example, was a patient charged for an operating room when the procedure was done in a regular exam room?

4. Are the times correct? As much as we want to charge for every second, some things can only be charged in 15-, 30-, or 60-minute increments. Do not "round up" when notes or reports don't support it. For instance, if the patient was seen for 25 minutes, I would bill one 30-minute session or two 15-minute sessions (as appropriate to the service/code descriptor). If the patient was seen for 16 minutes, I would bill for one 15-minute session.

Recently, I audited a bill for a patient receiving inpatient therapy services. The patient was charged for services he could not have received because he was in a comatose state. The bill indicated that several times a day he received over 30 minutes of charges for gait training or therapeutic exercises. Review of the notes showed that he had received only 15 minutes of actual work.

5. Have you over-coded? This is where a more expensive procedure/service is charged when a lesser one would do. For example, a name-brand medication was billed instead of the generic alternative provided; or, a longer office visit that includes paperwork time was reported when only the actual face-to-face time should have been charged.

6. Are the quantities and items correct? Did the patient really have 10 aspirin, or was it just one? Watch out for too many zeros.

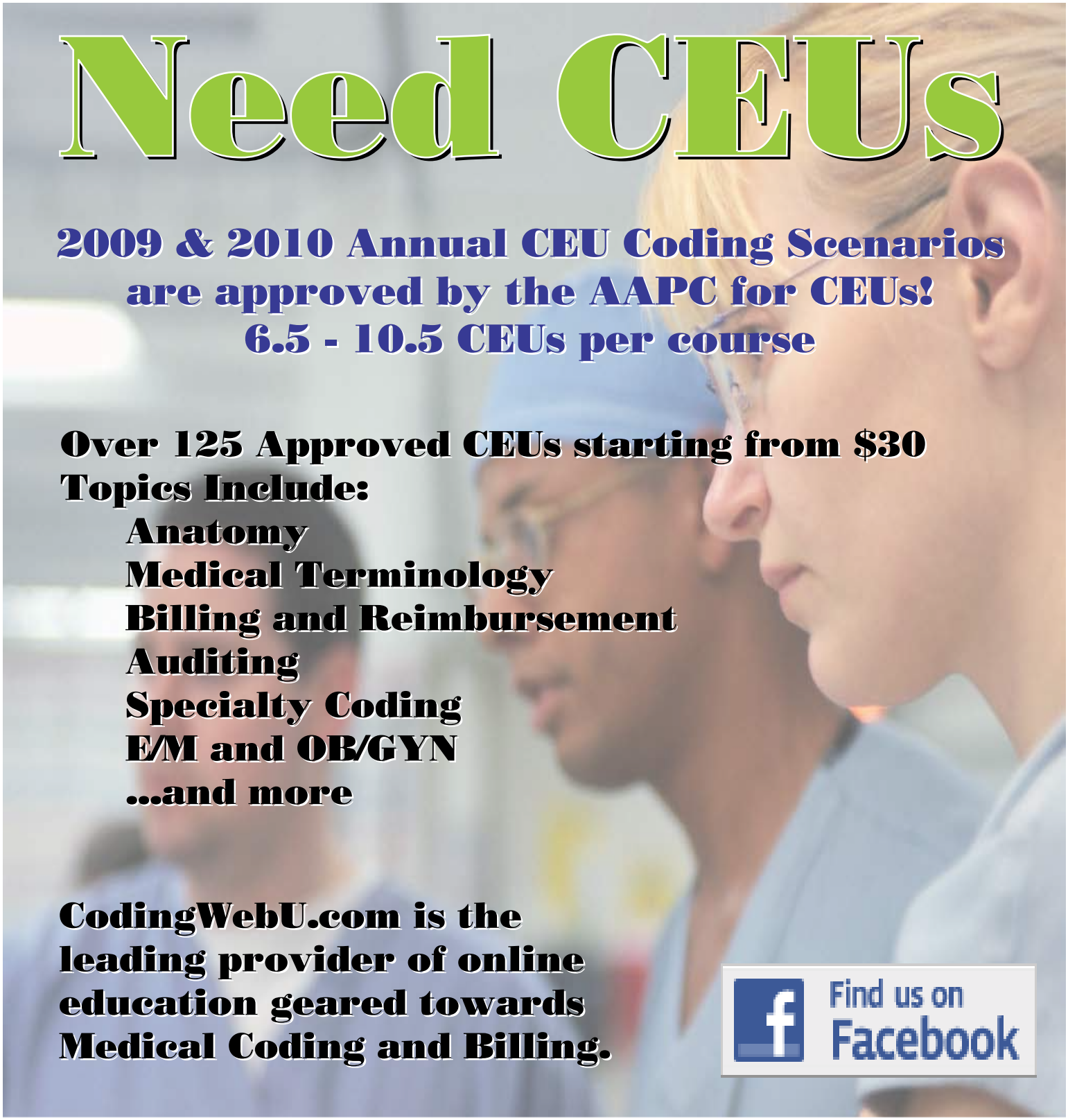
7. Are there overcharges or unbundles? Are you charging for items that can be included in the cost of something else? I have seen frequent unbundling of lab panels, for instance.

During a recent audit, we discovered that all the components of a comprehensive lab panel were billed individually. When we pointed this out to the facility, we were told the tests always were billed individually because the reimbursement was greater and no one challenged it. This is exactly the type of billing/coding you don't want to do.

Items associated with the room are another area in which I frequently see hospitals charging inappropriately. Do you pay extra for towels, gowns, sheets, etc., in a hotel? No: They are included in the price of the room. The same should be true in the hospital.

When entering data, I check my work either prior to submission (for small projects), or even every hour (for large projects). Taking a few moments to check over what you've entered on the bill will prevent even more time-consuming questions from coming up later. CE

Beth Morgan, CPC, MCS-P, is known as a medical bill detective or medical bill buster because she detects errors/overcharges on hospital/medical bills and assists providers in reducing their outstanding accounts receivable (A/R). Beth can be contacted at Beth@MedicalBillDetectives.com.



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Sleep Apnea:
The Not So Silent Bed Partner

High blood pressure, heart failure, unruly seizures, ADD, diabetes, and distorted metabolism may all be linked to sleep apnea.

By I. A. Barot, MD

PROFESSIONAL

"The Nightmare" John Henry Fuselli. The Detroit Institute of Fine Arts. Public domain

Sleep studies are an essential tool in diagnosing sleep apnea. The symptoms of sleep apnea—including interrupted sleep, snoring, and daytime sleepiness—often are considered normal, and thereby are dismissed as inconsequential. In fact, such manifestations are not normal, and are allied with other serious problems. Snoring, for instance, has been linked independently to both hypertension and heart disease.

Proper Identification and Treatment Yields Significant Results

Proper diagnosis and treatment of sleep apnea can have important patient benefits. For example:

- Over 80 percent of patients on three or more blood pressure medicines—regardless of complaints regarding sleep—suffer from sleep apnea. Appropriate treatment of their apnea over a period of several weeks results in a substantial blood pressure reduction with no change in medication.
- Up to 50 percent of patients with heart failure suffer from complex sleep apnea, and treatment improves quality of life for these patients consistently.
- Seizure patients who are treated for sleep apnea have better seizure control with less anti-epileptic medication (and therefore fewer side effects).
- Headache patients have improved headache control with a need for less abortive and preventative medications (thereby once again reducing side effects) after treatment of co-morbid sleep apnea.
- Sleep apnea patients tend to have a distorted metabolism. Cortisol, leptin, and ghrelin (three fat and appetite hormones) are dependent upon normal sleep and a healthy sleep/wake cycle. When disrupted by sleep apnea, the release of these hormones is interrupted. Sufferers become abnormally hungry—craving carbohydrates and fatty foods and abnormally depositing fat—while their fat metabolism is slowed. Overall metabolism also is affected, and as such sleep apnea patients gain weight, which perpetuates a vicious weight gain/apnea cycle and increases the risk of diabetes (cortisol releases glucose). On the converse, when patients are treated properly for sleep apnea, not only do levels of alertness and energy improve (facilitating desire for exercise), but also carbohydrate craving decreases, metabolic rate increases, and glucose levels improve—all of which may result in significant weight loss.

Symptoms May Be Misleading

Sleep apnea commonly is under- or misdiagnosed. For example, memory disturbances plague millions of Americans and often are diagnosed as Alzheimer-type dementia, particularly when other "reversible causes" of memory loss are excluded (e.g., seizures, vitamin deficiencies, brain lesions, endocrine problems, etc.). Typical cognitive complaints of sleep apnea patients include difficulty remembering names, finding words, and short-term recall. Yet, how often do we think about sleep apnea before starting expensive, disease-modifying therapeutic agents aimed at slowing cognitive decline?

Typical psychiatric disturbances in patients with sleep apnea include irritability, mood changes, and depressive symptoms. How many patients with these mood disorders are screened for sleep apnea?

Millions of Americans are taking prescription antidepressant medications for a diagnosed primary mood disorder. Typical psychiatric disturbances in patients with sleep apnea include irritability, mood changes, and depressive symptoms. How many patients with these mood disorders are screened for sleep apnea?

Apnea Can Affect Anyone

Often, we imagine the sleep apneic to be an obese, thick-necked drowsy male who snores loudly and who stops breathing during sleep (according to his bed partner's witnessed report). If it were that simple, sleep studies would have little necessity. In fact, most sleep apneics are not obese; many thin or normal build people suffer from severe forms of sleep apnea, and most patients have subtle complaints that can be elicited only when appropriate questions are asked.

Often, sleep-related breathing disorders are due to upper airway dynamics, often starting at the level of the soft palate. Due to anatomy (airway size, craniofacial characteristics, tongue size, soft palate position, etc.), certain ethnic groups (including Asians and African Americans) are particularly predisposed to more severe forms of sleep apnea, and it probably isn't a coincidence that these populations have an increasing incidence of heart disease, diabetes, and refractory hypertension.

Children with sleep apnea may present with different symptoms. Although some children have snoring, gasping, and witnessed difficulty breathing during sleep (each of which should prompt a referral to a qualified sleep specialist), many do not have such obvious sleep-related breathing issues. Restless sleep (poor sleeping), recurrent sleep terrors, bedwetting after the age of four years, habitual mouth-breathing (day or night), regular episodes of reflux, poor growth (failure to thrive), and symptoms of attention deficit disorder (ADD)/attention deficit hyperactivity disorder (ADHD) warrant a comprehensive sleep apnea screening. A subsequent sleep medicine consultation, sleep studies (if indicated), and appropriate treatment (e.g., surgery, rapid maxillary, mandibular expansion (RME), nasal continuous positive airway pressure (nCPAP, maxillomandibular advancement (MMA), etc.), can help restore sleep, correct deficient growth patterns, eradicate bedwetting, eliminate reflux, and improve school performance.

Because apnea has a genetic component (probably due to anatomic factors such airway size, mandibular deficiency, nasopharyngeal tissue, etc.), biological parents of children who are diagnosed with sleep apnea should consider being screened themselves.

Coding Apnea for Accuracy

Sleep apnea may be due to any number of causes, and may manifest with related conditions such as insomnia:

- **327.20** *Organic sleep apnea, unspecified*—obsolete term for medical cause of sleep apnea.
- **327.21** *Organic sleep apnea; primary central sleep apnea*—same as above, except no respiratory effort.
- **327.23** *Organic sleep apnea; obstructive sleep apnea (adult) (pediatric)*—repeated episodes of airway collapse with associated decrease in oxygen levels and autonomic changes with respiratory effort.
- **327.29** *Other organic sleep apnea*—sleep apnea not otherwise specified.
- **780.51** *Sleep disturbances; insomnia with sleep apnea, unspecified*—sleep apnea with primary symptoms of difficulty sleeping.
- **780.53** *Sleep disturbances; hypersomnia with sleep apnea, unspecified*—sleep apnea with primary symptoms of excessive daytime sleepiness.
- **780.57** *Sleep disturbances; unspecified sleep apnea*—sleep apnea without specific etiology.

We are in the midst of a symptom-based medical environment: Complaints are treated with medicines because our culture seeks instant gratification. For instance, when our blood pressure is above 140/90 mmHg, we automatically are prescribed medicine or our current medicines are altered. We have become adept at treating numbers to bring them within acceptable levels. The long-term result of this approach, however, has included overzealous expenditure of health care dollars, increasing utility of already overstretched resources. Yet, we are left with the same dilemma (i.e., an increasingly diabetic, overweight, hypertensive, cardiac-unhealthy, depressed, ADHD population). We are becoming increasingly aware that proper diet and exercise are instrumental in prolonging lifespan and improving quality of life. Identifying and treating sleep apnea in at-risk patients can foster the same while reducing both health care cost and disease burden.

I. A. Barot, MD, is a diplomat of the American Board of Psychiatry and Neurology and the American Board of Sleep Medicine, a fellowship-trained sleep disorders specialist, director of Sleep Labs at Virginia Neurology & Sleep Centers, and an assistant professor at Eastern Virginia Medical School.

APPRENTICE

Monitor Disturbances in Sleep Study Coding

Get the basics on sleep testing documentation and alleviate tired coding.

By Nancy G. Higgins, CPC, CPC-I, CIRCC, CPMA, CEMC

Sleep testing (CPT® 95803-95811) is performed to diagnose a variety of sleep disorders, including sleep apnea and narcolepsy, and to evaluate a patient's response to treatment methods such as continuous positive airway pressure therapy (CPAP). As a compliance specialist who audits sleep study documentation, I'm often asked what documentation is required for commonly-used codes, and how to determine the appropriate code based on the documentation provided. Here are the basics.

Polysomnography

One of the most commonly performed sleep studies, polysomnography, includes sleep staging with varying numbers of "parameters of sleep" studied. Parameters of sleep are simply various physical functions that can be measured. For example, brain waves (measured by an electroencephalogram (EEG)), heart rate (measured by an electrocardiogram (ECG)), and oxygen saturation (measured by pulse oximetry) are all considered parameters of sleep.

CPT® 2010 defines sleep staging to include "a 1-4 lead electroencephalogram (EEG), an electro-oculogram (EOG), and a submental electromyogram (EMG)." The EEG is used to measure brain waves, the EOG measures eye movements, and the EMG measures muscle movement in the submentalis muscle. To qualify as polysomnography, these three measures must be recorded in the documentation.

CPT® describes additional parameters of sleep that also may be recorded. These include "(1) ECG; (2) airflow; (3) ventilation and respiratory effort; (4) gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis; (5) extremity muscle activity, motor activity-movement; (6) extended EEG monitoring; (7) penile tumescence; (8) gastroesophageal reflux; (9) continuous blood pressure monitoring; (10) snoring; (11) body positions, etc."

Polysomnograms typically are performed at a sleep center where the patient stays overnight. Note that these studies (as well as the other types of sleep studies described in CPT®) require continuous monitoring and recording for six or more hours. If less than six hours of recording takes place, modifier 52 *Reduced services* should be appended to the CPT® code to identify a reduced service. An example of appropriate use of modifier 52 is when a 35-year-old female who is suspected of having sleep apnea has to leave the sleep study after four hours of testing due to the illness of her child.

CPT® identifies three codes for polysomnography:

95808 Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist

95810 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

95811 Polysomnography;sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

CPT® 95808 and 95810 identify diagnostic polysomnograms. The documentation for these studies often is labeled "Diagnostic Polysomnographic Report." CPT® 95808 requires sleep staging plus recording of *one to three* additional parameters of sleep. Code 95810 requires sleep staging plus recording of *four or more* additional parameters of sleep.

The aforementioned sleep parameters' documentation often is made in a table of numerical values, and may include a graphical analysis. Documentation also must include an interpretation and report by the physician. Interpretations typically describe the reason for the study, the overall study findings, and any abnormalities

discovered during the recording process. A diagnosis of the patient's condition, if any, is documented. Recommendations for treatment and/or follow-up testing often are included, as well.

Code 95811 requires sleep staging with four or more additional parameters of sleep and includes initiation of treatment. Treatment consists of continuous CPAP or bilevel ventilation. The reports used to support 95811 are sometimes labeled "Split Study Report" or "Split Night Sleep Study Report." Documentation to support this code would include the requirements described above for CPT® codes 95808 and 95810, as well as specific information about the treatment initiated (mask used, pressure recommended, etc.), including whether it was successful in helping the patient.

The following example demonstrates a typical physician interpretation and report from a diagnostic polysomnogram. The patient is a 51-year-old female who has been experiencing increasing fatigue and sleepiness during the day. The patient's husband indicated that the patient snores and seems to "quit breathing" periodically when she is asleep.

In addition to the report, the chart also contains detailed recordings of five parameters of sleep measured for this patient. The combination of these recordings along with the physician's interpretation and report support the billing of CPT® code 95810.

DIAGNOSTIC POLYSOMNOGRAPHIC REPORT

Patient: Jane Doe **Date:** 1/26/2010 **Physician:** John Doe, MD
DOB: 3/10/59 **Referring Physician:** James Smith, MD
Height: 5'11" **Weight:** 240 lbs **BMI:** 33.5

PHYSICIAN IMPRESSION

Obstructive Sleep Apnea, Moderate (327.23)

- The findings demonstrate moderate obstructive sleep apnea worse during supine-REM sleep. The apnea/hypopnea index was 10.5 and the respiratory disturbance index was 17.8 (average number of breathing obstructions per hour). Current guidelines define mild sleep apnea with an RDI of 5-15, moderate 15-30, and severe greater than 30 respiratory events per hour.
- Moderate oxygen desaturations were noted with the lowest SpO2 level observed at 78%. The longest apnea was 20.1 seconds.
- Frequent loud snoring was noted.
- Periodic limb movements during sleep were not observed.
- The patient's ECG displayed normal sinus rhythm.
- Moderate sleep fragmentation was seen with 14.5 brief arousals (3 to 15 seconds long) per hour and 19 full awakenings during 330.5 minutes of total sleep time. Sleep fragmentation was primarily due to upper airway obstruction. Sleep architecture showed normal sleep efficiency of 90.5% (percent of time asleep), sleep onset latency of 8.5 minutes, reduced REM sleep latency of 63.5 minutes, 6.5% stage N1 sleep, 54.6% stage N2 sleep, 24.1% stage N3 sleep, and 14.8% stage REM.

RECOMMENDATIONS:

- CPAP titration advised given history of atrial fibrillation.
- Treatment options would include treatment with nasal CPAP which would be the most rapid method of overcoming the upper airway obstruction that was noted. Other options would include consideration of a variety of surgical techniques as well as use of a dental appliance.
- Weight loss is recommended through permanent lifestyle modifications involving exercise and dietary restrictions as a long term goal to address one of the factors contributing to this condition.
- Avoidance of sleep deprivation is advised to prevent daytime sleepiness.
- Driving or use of heavy or dangerous machinery when sleepy should be avoided.
- Avoidance of alcohol and sedatives with muscle relaxation properties in the evenings is recommended in order to reduce upper airway relaxation.

John Doe, MD

Home sleep diagnostic testing devices provide simple, cost-effective, and reliable results.
Photo by Count Riddich

Multiple Sleep Latency Test

A multiple sleep latency test is a daytime sleep study that measures how sleepy the patient is and how long it takes the patient to fall asleep. The patient is asked to relax in a quiet room for about 30 minutes while the technician observes the patient and monitors various parameters. The test typically is repeated four or five times throughout the day, with breaks between the tests. The test records whether the patient falls asleep and what types and stages of sleep the patient is in. Sleep has two basic types, rapid eye movement (REM) and non-REM. This test is used to diagnose conditions such as narcolepsy and idiopathic hypersomnia.

Documentation for a multiple sleep latency test should include information about each relaxation period and what the monitoring indicated for those periods. As with the other types of sleep studies, a minimum of six hours of monitoring and recording is required.

This test is reported using 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness.*

Maintenance of Wakefulness Test

Similar to the multiple sleep latency test, the maintenance of wakefulness test takes place during the day. This study measures a patient's ability to stay awake and alert. The patient is asked to sit in a comfortable position, look straight ahead, and try to stay awake. This study usually includes four trials of 40 minutes each, with breaks between the trials. This study also is reported with 95805.

Documentation for the maintenance of wakefulness test should include information about each trial with a minimum of six hours of monitoring and recording.

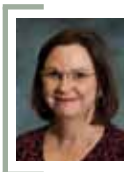
Actigraphy Testing

Actigraphy testing is done to study a patient's circadian rhythms and sleep schedule. It can be used to diagnose a number of sleep disorders including those related to jet lag and shift work. The patient wears an actigraph device on their wrist, ankle, or trunk. Actigraphy testing is performed continuously for a minimum of three days and as long as 14 days. Actigraphy testing is reported using 95803 *Actigraphy testing, recording, analysis, interpretation and report (minimum of 72 hours to 14 consecutive days of recording).*

As with the other studies, documentation for actigraphy testing should include an interpretation and report by the physician. The interpretation should describe the reason for the study, the overall study findings, and any abnormalities discovered during the recording process. A diagnosis of the patient's condition, if any, as well as recommendations for treatment, should be documented.

Coding Points to Remember

- The majority of sleep study codes require monitoring and recording for a minimum of six hours. If less than six hours of monitoring is completed, append modifier 52 to the CPT® code to indicate the service was reduced.
- If the physician performs only the interpretation of any sleep study, append modifier 26 *Professional component* to the CPT® code to designate professional service only.
- Each of the sleep study codes requires an interpretation and report by the physician. If this component is missing, the requirements for the global code are not met.
- As with all diagnostic studies, the name of the physician requesting the study and the reason for the request should be recorded.



Nancy G. Higgins, CPC, CPC-I, CIRCC, CPMA, CEMC, is a senior compliance specialist with Carolinas Healthcare System. She has over 20 years of experience in the health care industry and is the immediate past president of the AAPC Charlotte, N.C. chapter. Nancy was recently named AAPC 2009 Coder of the Year.

LEGAL Edge

ASK THE LEGAL ADVISORY BOARD

WHAT'S A CODER'S LIABILITY?

Question: *Some of my local chapter members approached me last night about a situation: They originally were hired to audit physician coding before claims were submitted. A new practice manager has come in, and now the coders are told to enter whatever the physician circles on the encounter form for the CPT®, to code the ICD-9-CM, and not to audit the records. They are wondering what their liability is?*

Name and location withheld by request

Response: Generally, a coder will not incur liability for physician billing errors. My thinking here is that the coder is relying upon physician documentation for purposes of assigning a code. If the physician documented more services than he or she provided, the coder has no way of knowing that and would not be liable. My experience in resolving matters with the federal government is that coders often end up being fact witnesses (and excellent ones, at that) as to how the office operated and how the services were billed.

If the coder knows the provider is engaged in fraudulent activities (i.e., documenting patient visits or ordering durable medical equipment (DME) for patients that either don't exist or were not seen), then the coder would also bear some liability for knowing and participating in the billing scheme. I often advise coders that if they suspect their physician or other provider is up to no good, they should quit. I often hear the response, "I can't afford to quit," to which I respond, "You can't afford to stay." Continuing to participate cannot only establish liability, it can lead to loss of your CPC® credential, exclusion from participation in federal health care programs, and effectively end your career.

I often advise coders that if they suspect their physician or other provider is up to no good, they should quit.

Julie E. Chicoine, Esq., RN, CPC, has served both as in-house and external legal counsel for health care organizations providing guidance on a variety of health care regulatory issues. She has particular expertise in reimbursement, documentation, and coding issues. Julie formerly served as director for the Ohio State University Medical Center's compliance program and now serves as a senior attorney there. Julie earned her Juris Doctor degree from the University of Houston Law Center. She also holds a bachelor of science and 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.

Take the Hurt Out of Post-op Pain Block Coding

By Jennifer Hritsco-Murray, CPC, CANPC

Understand location and documentation to target the correct codes.

Under Medicare guidelines, pain management following surgery usually is included in the surgeon's global fee and may not be billed separately. If another physician (such as an anesthesiologist) provides pain management at the surgeon's request, however, it's possible to report the service independently.

Specifically, according to the American Society of Anesthesiology (ASA), CPT® recommendations, Correct Coding Initiative (CCI) edits, and the Centers for Medicare & Medicaid Services (CMS) guidelines, when medically necessary a block performed for post operative pain only (which is not a part of the anesthesia service) may be billed separately with the proper modifier. The surgeon is responsible for documenting in the patient's medical records why post-op care was given to the anesthesiologist.

Account for Time Appropriately

You must pay attention to block placement timing, and be sure that your anesthesiologist is not billing time plus the flat rate fee inappropriately.

Do *not* deduct time for the block when:

- **The block was done in the holding area before anesthesia time had started.** Depending on the patient and the anesthesiologist, the block may be done in the holding area before the patient is taken into the operating room (a block may be done prior to the surgical procedure even though the block is for post-op pain). Anesthesiologist time starts when the patient is preparing in the operating room (OR) for surgery. Your anesthesiologist should not start his time when the patient is in the holding area, so there is no need to subtract time for the block.
- **The block is part of the anesthetic itself.** For instance, if the anesthesiologist places a nerve block but the patient had intravenous (IV) sedation only, the block is considered part of a regional anesthetic and should not be billed separately. As an example, if a spinal block (such as 62311 *Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)*) is performed with IV sedation for a hip surgery, consider the block part of the regional anesthetic. Report the appropriate anesthesia code and time, but do *not* report 62311.
- **The patient is fully under anesthesia when the block is performed.** These cases are rare, but may occur; for instance, if the patient is unable to hold still to receive the block (for example, due to patient age or mental status).

You *should* deduct time for the block from the total surgical procedure's anesthetic time when:

- **The patient is in the operating room, the anesthesiologist has started his time, and the patient is not under induction** (ASA House of Delegates, Oct. 17, 2007 updated Sept. 2, 2008). In most cases the anesthesiologist would place the block prior to induction, for clinical and safety reasons.

For example, prior to placing the patient under general anesthesia, a block (for instance, 64415 *Injection, anesthetic agent; brachial plexus, single*) is given in the OR for post-op pain. The total time from when the patient was prepared, started, and finished equals 67 minutes, the anesthesiologist started his time when the patient was prepared for surgery in the OR. The anesthesiologist noted in his record that he placed the block after monitors were placed. Because the block was done prior to induction, don't count the time it took to place the block. It took him seven minutes to place the injection prior to induction so subtract the seven minutes from the 67 minutes, billing a total time of 60 minutes. In this case, the block may be billed (64415-59 *Distinct procedural service*) in addition to the general anesthesia code plus time (for instance, 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified.*

PROFESSIONAL

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Most often the documentation is there, and with a proper understanding of the nerve anatomy there is no problem verifying the correct code to use.

Remember: Add modifier 59 to any block codes not related to the anesthesia for the procedure.

Report What Documentation Supports

The physician should document the nerve he or she is targeting for post-op pain. Most often the documentation is there, and with a proper understanding of the nerve anatomy there is no problem verifying the correct code to use.

If documentation is unclear, do not make assumptions. Instead, ask the reporting physician for guidance. You can get the best results by asking physicians for clarification, and then helping those physicians understand what documentation is necessary to support the procedures or services performed. The better physicians understand documentation requirements, the more consistent and accurate your coding will be.

Consider this example: The physician documents popliteal fossa block for post-op pain of the lower extremity. The popiteal fossa is not a nerve—it is a triangular space just above the back of the knee where the nerve injection was approached. This triangle is where the sciatic nerve splits into the tibial and common peroneal nerve (the tibial and common peroneal nerves are branches of the sciatic nerves). In most cases, the popliteal nerve block is an approach for the injection of the sciatic nerve by the means of a prone positioned patient; however, the same area also can block the tibial or the common peroneal nerve.

Questions: Was the focus of the post-op block the sciatic, tibial, or common peroneal nerve? Is the appropriate code 64445 *Injection, anesthetic agent; sciatic nerve, single* or 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (there are no specific codes for the tibial or the common peroneal nerve listed in the CPT®)? If the physician documents precisely, it is not a hard question; however, in this case it's hard to determine because the documentation seemingly lacks enough information to support 64445. If the documentation lacks the support to code accurately, you must report 64450.

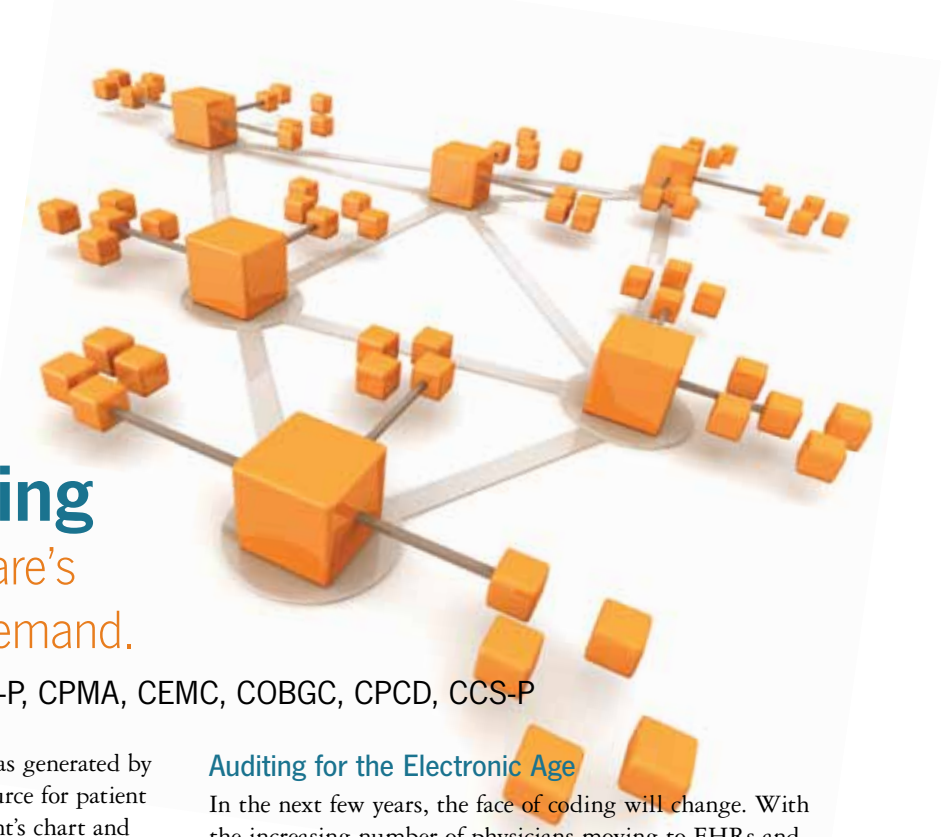
Hint: You may find documentation to support 64445 on the permanent record of the real-time ultrasonic/ultrasound picture. The physician should've labeled the nerves and needle placement in the real-time image where the local anesthetic pool is located.

Guidance May Be Separate With Injection

CCI edits allow you to bill separately for ultrasonic guidance using 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* with modifier 26 *Professional component*, as long as your physician has permanent recording and reporting in the patient medical records. Ask your physician to provide a photocopy of this document. Attach it to the billing before you allow it to be coded and charged out. Look out for CCI edits going forward to be sure future edits do not change the rules for reporting guidance with injection.

Being a coder is like being a detective. You must look at all the "evidence"—including the ultrasonic guidance picture—and ask yourself what type of surgery this is, what the block is being used for, and whether the block was part of the anesthesia or provided by the anesthesiologist to control post-op pain. Call on all available resources (for instance, CCI edits, *CPT® Assistant*, and your local Medicare carrier local coverage determination (LCD)/national coverage determination (NCD)) to ensure your coding is valid. If you are unsure of anything, ask your physician for guidance and look again at the documentation. If the documentation doesn't support the code the physician wants to report, tell him or her why. Make sure you have support for your reasoning, and attach the information to the charge (or keep it in a folder). Such supporting documentation is especially important if you have to appeal a claim.

Jennifer Hritsco-Murray, CPC, CANPC, has worked in health care for 13 years, beginning as a Certified Nurse Assistant (CNA). She has been employed with Missoula Anesthesiology, PC for 10 years, and codes procedures for the Advanced Pain & Spine Institute of Montana since 2005. She is president-elect of the Missoula Chapter, where she previously served as new member development officer.



CPCs® Branch out into Medical Auditing

Coding crossroads to health care's future leave auditors in high demand.

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

PROFESSIONAL

Well over 20 years ago documentation was generated by the provider only as an information source for patient care. The information was housed in the patient's chart and kept in a file and only the physician and staff looked at the record. Now, with providers under heavy scrutiny by payers and government carriers, documentation has become important not only for medicolegal reasons but to support charges submitted for payment to the carrier. Medical malpractice claims have soared and the medical record serves as a legal document incorporating information about the patient's condition, care, and other important data from a clinical perspective. For the payer, the medical record supports the services billed to them and is used to defend malpractice claims as well as defend insurance fraud and abuse.

The Coding Profession Evolves

From 2007 to 2008 there was an 18.7 percent increase in physician practices adopting an electronic medical record (EMR)/electronic health record (EHR) system. Now with the stimulus package, even more physicians are adopting the EHR (Blumenthal D., "Stimulating the Adoption of Health Information Technology," http://content.nejm.org/cgi/content/full/360/15/1477). More money is being allocated by the federal government to fight health care fraud and abuse, as well. This means with the intensity of insurance carrier audits, and government programs like Recovery Audit Contractors (RACs), Medicaid Integrity Programs (MIPs), and Medicaid Integrity Contractors (MICs), etc., auditing has become an important piece of coding compliance. The new health care reform incorporates mandatory compliance, which also makes auditing even more important because coders, physicians, and other health care professionals must comply with government regulations.

Although balancing reimbursement challenges, productivity, and accuracy is difficult, coders must strive to maintain compliance as the government and all carriers are watching. The only way to determine whether coding is appropriate is to compare the clinical documentation in the chart to what was billed on the claim.

Auditing for the Electronic Age

In the next few years, the face of coding will change. With the increasing number of physicians moving to EHRs and with the current capabilities of computer assisted coding (CAC), the role of the coder might change to the role of an auditor, which includes reviewing documentation to ensure the computer selected the appropriate code. A computer cannot assess medical necessity nor can it understand medical policy. Coders will be needed to review the documentation to ensure coding compliance.

A medical coding audit can reveal whether a variation from the national average is due to inappropriate coding, insufficient documentation, or lost revenue. Coding audits can help identify problem areas that need correction before insurance or government payers challenge inappropriate coding.

With the costs associated with medical care and insurance escalating at an alarming rate, each year, billions of dollars are paid unnecessarily. The challenge we have is to train coders to take the next step into medical auditing. There is a shortage of good coding auditors in the industry and as we move into the electronic age in health care the demand will reach a critical state. Now is the time to think about how you can move your career forward to the next level.

Crossover into Auditing

Have you been coding for years and feel you need a change or to stretch your wings and learn more?

Some say coding and auditing are the same. This isn't true: Auditing is the process of analyzing the medical record with puzzle pieces you must put together. When auditing a medical record post-payment, you review the documentation and the services reported on the claim, what was reimbursed, and medical necessity. Good coders make good auditors. Medical coding auditors are like detectives, trying to find the missing link and researching to fill in pieces of the puzzle. If you enjoy investigative work, this career path is a great option for you.

"There is a shortage of good coding auditors in the industry and as we move into the electronic age in health care the demand will reach a critical state."

Auditing Is More Than E/M

Most people think of evaluation and management (E/M) services when they think of auditing coding. A well-rounded medical auditor audits more than E/M services. It's true, most providers will evaluate patients and provide E/M services; however, auditing is so much more. If you work in a surgeon's practice or a physical therapy practice, or for an ambulance service or a radiologist, you will not report a significant amount of E/M services. For example, a radiologist focuses on interventional procedures and diagnostic tests.

If you want to move your career forward into medical auditing, make sure to learn about all aspects of auditing, which include the following:

- E/M
- Surgical procedures
- Radiology services
- Therapy services
- Mental health services
- Ancillary services
- Accounts receivable

What Should a Medical Coding Auditor Know?

Simply, the medical coding auditor should understand fully:

- The structure and documentation principles of the medical record
- How to assess medical necessity
- Medical coding rules and concepts
- Compliance
- What insurance carriers are looking for
- How to investigate and research
- Insurance and government carrier policies
- Corporate integrity and requirements as an independent review organization (IRO)
- Adherence to protected health information (PHI)
- National Correct Coding Initiative (NCCI) and bundled services
- Comprehensive Error Rate Testing (CERT) Program, RACs, MICs, MIPs, etc.
- Fraud and abuse, self disclosure, stark, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and more

This is an abbreviated list showing that medical auditing is not just about reviewing medical records for appropriate coding and documentation—it's about understanding all the regulations associated with coding and billing.

What Does an Auditor Do?

Medical coding auditors examine coding patterns to evaluate how health care providers use coding to bill insurance companies. A medical coding auditor makes sure their physicians, non-physician practitioners (NPPs), fellow coders, and other medical staff are using the appropriate coding to maintain compliance. They evaluate whether providers are complying with local, state, and federal regulations and adhering to internal coding standards so the health care provider is billing the correct amounts. Medical coding auditors may work closely with and prepare reports for health care providers or his or her management team to provide information to help set their compliance and financial goals.

A similar job is the coder/revenue analyst. Because it requires examining of accounts payable and receivable and a background in coding, it's ideal for business minded individuals. The coder/revenue analyst examines coding data and identifies problem areas that could cause a loss of revenue for a health care provider. He or she helps develop solutions to stop revenue loss while a medical auditor or consultant is engaged reviewing the accounts payable and/or receivable to identify errors, lost revenue, and ensure compliance.

Where Do You Begin?

Coders who seek an auditing position should be experienced in medical coding and hold coding certification. If you are a certified coder with at least five years of coding "in the trenches" experience, consider auditing. Most auditing positions require five years of hands-on coding experience.

It's helpful to attend seminars, workshops, conference, and even an auditing class. You cannot learn to audit in a couple of days; however, for the seasoned coder, a two- or three-day course might be a good start. It does take a few years to sharpen your skills and become a seasoned auditor. Taking a three- to six-month auditing course will help a well-vetted coder to the next level. Once you have taken a course and learned how to audit, you are ready become certified. AAPC offers the Certified Professional Medical Auditor coding credential (CPMA™), which will help you to a new position, or strengthen your day-to-day work at your current organization.

With motivation, leadership skills, and credentials, an experienced medical coder can move up to a medical coding auditor and bring in an excellent income. While employers sometimes look for candidates with a degree, many employers value equivalent experience in the field. If this career path is something you have considered, visit AAPC's website at www.aapc.com and learn how you can prepare to become a medical coding auditor and earn your CPMA™. Good luck!

Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P, is president and CEO of AAPC.

HIPAA Privacy: A New Era of Awareness and Enforcement

Avoid getting caught in HIPAA traps set by your privacy officer.

By David Behinfar, JD, LLM, CHC, CIPP

It has been over seven years since the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule became effective for most covered entities. As public awareness of health care privacy issues has increased since 2003, efforts at privacy rule enforcement also have accelerated. One consequence is that it is much easier for health care workers—including coders—to find themselves in a privacy officer's crosshairs.

Before I share my advice on how to avoid the wrath of your friendly local privacy officer, let's discuss factors leading to greater awareness and enforcement of the HIPAA Privacy Rule.

Privacy Rules in the Limelight

1. The Office of Civil Rights (OCR), which is responsible for oversight and enforcement of the Privacy Rule and, as of Aug. 3, 2009, the HIPAA Security Rule (see www.hhs.gov/news/press/2009pres/08/20090803a.html), is now an experienced and established regulatory oversight agency. The OCR is skilled at processing patient privacy complaints, of which it has handled more that 43,000 since April 2003 (www.hhs.gov/ocr/privacy/hipaa/enforcement/data/historicalnumbers.html).

   OCR also has begun to impose serious corrective actions upon covered entities. For instance, OCR recently (July 16, 2008) entered into a resolution agreement with Providence Health & Services, imposing a three-year corrective action plan and fines (referred to by OCR as a "resolution amount") in the amount of $100,000 (see www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/providenceresolutionagreement.html). A similar agreement with CVS Pharmacy, Inc. (July 16, 2009) included a fine that totaled a whopping $2.25 million (www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/cvsresolutionagreement.html). The OCR's experience and willingness to fine covered entities demonstrates a changed environment for privacy enforcement.

2. State attorneys general (AG) now have a stake in enforcing the HIPAA Privacy Rule. The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 allows state attorneys general to enforce the HIPAA Privacy Rule—with authority to institute fines up to $25,000, plus attorney's fees.

   Connecticut State Attorney General Richard Blumenthal is the first AG to exercise this option. In January 2010, Blumenthal filed suit against a health insurer for failing to secure 44,000 patient records and promptly notify patients of this breach, and in March he filed a second investigation against a physician for allegedly improperly accessing more than 1,000 patient records (www.ct.gov/ag/cwp/view.asp?A=2341&Q=453918 and www.ct.gov/ag/cwp/view.asp?A=2341&Q=457882).

3. A greater number of people now understand their specific privacy rights. When I first began educating our physicians and staff on the HIPAA Privacy Rule in April 2003, this was a new topic for my audience. Since 2003, however, thousands of health care workers across the country have repeated their privacy training annually. I've also encountered many individuals in other professions (legal, law enforcement, insurance, business) who in conversations clearly indicate their knowledge of HIPAA privacy.

The reporting of numerous privacy breaches by the media has made the public more aware of how covered entities' failure to protect information can harm patients. Many states have had some form of security breach notification law in place for years (see www.crowell.com/pdf/SecurityBreachTable.pdf), resulting in written notification to patients of these privacy/security breaches involving their information. Now, there is an added layer of federal legislation that also requires the notification to patients of certain breaches involving patient information (see www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/breachnotificationifr.html). As part of this new federal breach notification rule, covered entities must report all of their privacy breaches to the U.S. Department of Health & Human Services (HHS) annually. Privacy breaches involving 500 or more patients also must be reported "without unreasonable delay" and are posted on the HHS website in a running tab format (www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/postedbreaches.html).

EXPERT

Another target is an access into an account of a co-worker or even someone who appeared in the local media (e.g., people injured on a nearby major interstate highway or children who were injured in a tragic accident that was reported on the local news).

Greater awareness of privacy rights isn't a bad thing. With a more experienced government regulator, state AGs who are incentivized to enforce the HIPAA Privacy Rules, a smarter public, and patients barraged with notices of privacy breaches, privacy professionals have become better at what they do to manage privacy compliance efforts at their institutions.

HIPAA Compliance for Coders

What are the lessons for a coder? In my experience, these three stand out as the easiest to implement and most important:

Lesson No. 1: If you use a portable electronic computing device or media (laptop, thumb drive, USB drive, flash drive, external hard drive, etc.) for any work involving patient information, *make sure your device is encrypted.* This is probably the most serious and potentially costly privacy/security violation.

Every health care institution across the country has (or should have) a policy in place requiring any portable electronic computing or media device that stores, transmits, or creates patient information be encrypted. On the HHS website listing large (500+) breaches, more than 70 percent of the breaches listed thus far (through June 2) are due to a "theft" or "loss" of patient information—most of which involve a stolen or lost portable electronic computing or media device.

If you use an un-encrypted portable electronic computing or media device for patient care-related activities, call your privacy officer and ask him or her to explain the encryption requirements of your institution. Follow up to be sure you meet the requirements.

Lesson No. 2: *Unauthorized access of a patient's record* is another cardinal privacy rule that should not be broken. Do not access patient information on electronic systems (or paper charts, for that matter) for any patient whose records you are not authorized to access for legitimate business purposes.

Accessing the records of a public figure or athlete without a "business" need-to-know is an obvious fatal error in judgment. The business need-to-know basis for accessing patient records also extends to accessing records of your family, co-workers, and friends. "Same last name" audits are, in fact, a popular audit focus. For instance, if your last name is Klammerstein, and I as a privacy officer pull your name for a random audit and see you accessed the account of three other Klammersteins on our electronic medical record (EMR) system, my alarm bells will start ringing. Another target is an access into an account of a co-worker or even someone who appeared in the local media (e.g., people injured on a nearby major interstate highway or children who were injured in a tragic accident that was reported on the local news).

There are great advancements in auditing tools as part of EMR systems, so much of the data can be collected and sorted in just a few clicks. As such, it is in your best interest to assume your activities will be monitored whenever you are accessing patient information.

When accessing a patient record ask yourself if you have a "business" need to access that record. If the answer is "no," then you are likely in violation of your institution's privacy policy regarding authorized access to patient information.

Lesson No. 3: *Encrypt e-mails to people outside your institution if they contain patient information.* Once again, learn your institution's policies. If you are e-mailing patient information in spreadsheets or attachments, or including it in the body of an e-mail to parties outside of your institution, your institution may require you to send those e-mails in encrypted format. Failure to encrypt an e-mail containing patient information to a third party may be considered a privacy breach, requiring notice to all affected patients whose information was included in the e-mail. A transmission across the internet in an unencrypted format is perceived as an apparent risk because there's a chance the e-mail may be intercepted during transmission.

Important Lessons Learned

If you carefully consider and learn from these lessons, you will greatly diminish the likelihood your privacy officer will call you into his or her office to discuss employment termination for violating your institution's privacy policies. Of course, there are other privacy policies with which you will need to be familiar; but in the world of coding, the three aforementioned lessons are likely to be the most important in protecting your livelihood. CE

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Road Map to ICD-10-CM
Get Your ICD-10 Questions Answered

Get Your ICD-10 Questions Answered

Put yourself in a good position to assist your organizations.

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

The ICD-10 Roadmap has led us to the countdown to implementation. If your practice, health plan or organization has not started thinking about the ICD-10 transition, the time to start is NOW! I cannot stress this enough—if you do not begin the process now, your organization could be at risk financially.

Widespread confusion about ICD-10 exists throughout the industry. Getting answers to your hard-pressed questions will ensure a smoother transition in 2013. The following are the most common ICD-10 questions we have received at AAPC:

Q1: *Is the Oct. 1, 2013 compliance date for ICD-10 implementation flexible? Will the go-live date be delayed?*

A: All covered entities of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 MUST implement the new code sets on Oct. 1, 2013.

Q2: *Is the ICD-10-CM effective date based on service date or submission date for outpatient services?*

A: For all outpatient services, including ambulatory and physician services, the date of service is the effective date. For inpatient hospital facility reporting, if the patient is admitted prior to Oct. 1, 2013 and discharged after Oct. 1, 2013, the discharge date is the key determining factor whether an ICD-9-CM code or ICD-10-CM/PCS code is reported.

Q3: *Will the U.S. Department of Health and Human Services (HHS) grant an extension beyond the Oct. 1, 2013 date? It is typical of HHS and the Centers for Medicare & Medicaid Services (CMS) to delay.*

A: HHS has no plans to extend the compliance deadline date ICD-10-CM/PCS implementation. All covered entities should plan to complete the steps required to implement ICD-10-CM/PCS, and get ready to go live on Oct. 1, 2013.

Q4: *Non-covered entities are not covered under HIPAA. This includes workers' compensation and auto insurance companies that use ICD-9-CM and use older versions of ICD-9-CM. Are they mandated to move to ICD-10-CM/PCS?*

A: No. However, because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in the non-covered entities' best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to non-covered entities. Hopefully, many workers' compensation and auto insurance companies will implement ICD-10 along with the covered entities.

Q5: *Modifier 50* Bilateral procedure *is not applicable to diagnosis coding but applicable to CPT®. Would the laterality in ICD-10-CM, help support the use of modifier 50 on a CPT® code?*

A: Laterality in ICD-10-CM is reportable for many ICD-10-CM codes. Many ICD-10-CM codes identify the left and right side of the body and bilateral. If a procedure or service is reported bilaterally, the specificity in ICD-10-CM would help support use of modifier 50. The American Medical Association (AMA) has made no assumptions that modifier 50 will be eliminated from CPT® nor has any discussion taken place so far to eliminate modifier 50 from CPT®. Keep in mind that not all ICD-10-CM codes support laterality.

Q6: *Do you think there will be a transition time when we will be submitting both ICD-9-CM and ICD-10-CM codes at the same time for different payers/carriers?*

A: No. There has been no indication that we will use both ICD-9-CM codes and ICD-10-CM codes simultaneously. Beginning Oct. 1, 2013, we must begin using ICD-10-CM codes. This includes hospitals, physicians, ambulatory services, health plans and all other health

care providers. We will however need to utilize both ICD-9-CM and ICD-10-CM/PCS until all outstanding, pended, or appealed claims for services rendered prior to Oct. 1, 2013 are resolved.

Q7: *Will ICD-10-PCS be required to report diagnoses for physician (professional) and outpatient services?*

A: ICD-10-PCS will not affect coding of physician or outpatient services provided in the outpatient setting; however, physicians should be aware documentation requirements under ICD-CM-PCS are quite different. Their inpatient medical record documentation will be affected by this change.

Q8: *Will unnecessary detailed medical record documentation be required when ICD-10-CM/PCS is implemented?*

A: As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn't support a higher level of specificity. Keep in mind, however, you need to use caution when selecting an unspecified ICD-10-CM code as the purpose of moving to ICD-10-CM/PCS is the detail and specificity, which may reduce requests by payers/carriers for documentation and provide a greater support of medical necessity.

Q9: Can *ICD-10-CM/PCS implementation can wait until after electronic health records (EHRs) and other health care initiatives have been established?*

A: Implementation of ICD-10-CM/PCS cannot wait for the implementation of other health care initiatives. As management of health information becomes increasingly electronic, the cost of implementing a new coding system will be greater due to required systems and applications upgrades. If you are planning to implement an EHR it might be a good time to do so during the ICD-10-CM/PCS implementation process.

Q10: *If various countries have their own version of ICD-10, how can the information really be transferable for one country to another?*

A: The World Health Organization (WHO) has standards that a country must adhere to if they want to create their own version and those rigorous standards allow for interoperability between the various versions. The 'base' set of information across all of ICD-10 is comparable between each clinical modification in use.

Q11: *What is the estimate timeframe for the ICD-9 to ICD-10 conversion for an EHR system?*

A: Vendors of EHR systems have the same compliance requirements as providers and health plans. In other words, they also need to be compliant on Oct. 1, 2013.

Q12: *I have been reviewing the ICD-10-CM codes since I am responsible for implementation in my practice. Can you explain the seventh character extensions on the ICD-10 format?*

A: ICD-10-CM has added alpha character extensions (seventh character) to codes in the appropriate sections to provide specific information about the characteristics of the encounter. For example, in the injury and external cause sections, the extension classifies an initial encounter, subsequent encounter, or sequela of an encounter. Extensions have different meanings depending on the section. A few common extensions are:

A-Initial encounter
D-Subsequent encounter
S-Sequela

Extensions are also used to indicate trimesters of pregnancy:

1. First trimester
2. Second trimester
3. Third trimester

There are also extensions to indicate laterality:

1. Right
2. Left
3. Bilateral

Q13: *Is there a big difference between ICD-9-CM and ICD-10-CM?*

A: The differences between ICD-9-CM and ICD-10-CM are significant. Even though the format and structure remains primarily the same as ICD-9-CM, the specificity is much greater.

Q14: *What is 5010? What is the relationship between 5010 and ICD-10-CM?*

A: Version 5010 will replace 4010/4010A1 for electronic transactions. The compliance implementation date for 5010 for physicians is Jan. 1, 2012. Version 5010 will accommodate the ICD-10 code sets, and has

an earlier compliance implementation date to ensure adequate testing time for the industry before moving to ICD-10-CM/PCS. Version 5010 addresses currently unmet business needs, including, for example, providing in institutional claims an indicator for conditions that were present on admission (POA). Version 5010 also accommodates the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1.

Q15: *Why should a small office purchase an electronic health record?*

A: Implementation of the EHR or electronic medical record (EMR) is not mandatory. Each individual medical office will need to assess whether an EMR will benefit the practice with quality reporting and efficiency. Complete and thorough investigation into types of EHRs and their benefits and barriers is imperative when considering an EHR.

Q16: *I have heard about AAPC's ICD-10 Tracker recently. What is it and where can I find it?*

A: The ICD-10 Tracker is available to all members. You must log into your member area on the AAPC website. Once logged in, on the top right corner of the screen is a heading ICD-10 Preparation with a stop and go light. You must select the size of your organization on the drop down list and click Save. You will be automatically directed into the implementation tracker. Implementation steps along with suggested timelines are listed on the tracker. After saving your ICD-10 Tracker, you will see a list of steps to keep you on track. By clicking on a step, you will be taken to a checklist of action items to complete for implementation.

After completing one of the actions, select the checkbox, and save your progress. You will be taken back to the list of steps on the tracker. If one of the actions is not applicable, select the checkbox and save. This alerts the system you have acknowledged the action and do not need to complete further action. The yellow lines by the track steps will start turning green as the actions are checked off. Steps have end dates. If one to two of these step end dates pass without all of the actions being checked off, then the progress light with turn amber warning you. If more than two of the step end dates pass without all of the actions being checked off, then the progress light will turn red warning you. There is a good illustration in the July 2010 *Coding Edge*. We created this tool to help the industry understand what steps are necessary when preparing for ICD-10.

Q17: *Will current AAPC certified coders be required to be recertified to hold their credentials?*

A: No, every AAPC certified coder will be required to take and pass an ICD-10-CM proficiency examination to validate their knowledge of ICD-10-CM. The exam will be an online 75-question, multiple choice exam, which will be available Oct. 1, 2012 through Sept. 30, 2014. The test will be open book, and any resources available to complete the exam may be used, including Internet, textbooks, or other materials. You must pass this examination to maintain certification. A certified coder will have two attempts at passing the exam for the $60 administration fee. Keep in mind other organizations not requiring a proficiency exam will require additional Continuing Education Units (CEUs) on ICD-10 coding and there are also fees involved in obtaining the additional CEUs.

Q18: *Will AAPC have practice tests and a study guide available to prepare for the test?*

A: Currently, we have the on-site and implementation boot camps, along with distance learning for implementation. We are working on additional training including general and specialty-specific ICD-10-CM/PCS coding training. We plan on creating several practice tests along with a study guide to ensure AAPC members are prepared for the transition.

Q19: *I am a CPC® with three specialty credentials. Will I need to take three proficiency exams?*

A: You will only be required to take one test regardless of how many credentials you hold.

Q20: *Will the CMS 1500 claim form be updated to accommodate the new codes?*

A: Yes, the CMS 1500 claim for will be revised in the near future to accommodate ICD-10-CM.

Q21: *What steps should a professional coder be taking, and timeframes, for learning the new codes to obtain their recertification and proficiency?*

A: Look to AAPC for training and education. Use the AAPC website and especially the member area to monitor your progress. We are planning training mechanisms and options from 2010-2014 and beyond. Distance learning, webinars, AAPC National Conferences, AAPC Regional Conferences, etc. Proficiency testing will begin Oct. 2012 and be offered through Sept. 30, 2014.

Q22: *Will there be changes to CPT® coding?*

A: CPT® and HCPCS Level II codes are not expected to change specifically due to ICD-10 related issues. CPT® and HCPCS Level II, however, will continue to be updated on their regular update schedule. Updates of these code sets should not be neglected due to the ICD-10 transition.

Q23: *Will there be classes available to prepare for the AAPC test and will there be courses to learn how to use and code ICD-10-CM and ICD-10-PCS for coders and physicians through AAPC?*

A: AAPC is developing for providers and health plans courses, distance learning modules, webinars on various topics, workshops, a three-day on-site curriculum, and 15-minute webinars for physicians and managers for ICD-10-CM training. The curriculum, courses, and education sessions will be taught by trained AAPC expert trainers. Our national and regional conferences will have many education sessions on various topics to assist in preparation for the exam. In 2013, the year of implementation, AAPC has planned eight regional conferences focused only on ICD-10-CM and ICD-10-PCS coving various topics for many specialties and health plans. Watch the AAPC website for updated information. Practice exams and other methods of education will be widely available to all persons involved in the health care industry to prepare for ICD-10-CM and ICD-10-PCS, and AAPC's proficiency examination.

Q24: *If our doctors consult a patient in an inpatient stay prior to Oct. 1, 2013, but the patient is discharged after Oct. 1, 2013, do we still use ICD-9-CM or following "discharge guidelines" by using ICD-10-CM?*

A: For physician or non-physician practitioner (NPP) reporting, the date of service is reported. For example, if the physician sees the patient on Sept. 30, 2013 and discharges the patient on Oct. 2, 2013, the physician would use ICD-9-CM on Sept. 30, 2013 and ICD-10-CM codes on Oct. 1- 2, 2013.

Q25: *I understand ICD-10-CM/PCS must be implemented by Oct. 1, 2013. Will there be a time prior to this date to submit the ICD-10-CM codes or will it be a 100 percent switch on one day?*

A: There will not be a time period prior to ICD-10-CM implementation to submit claims before Oct. 1, 2013. The switch to ICD-10-CM will occur on Oct. 1, 2013 for all covered entities; however, your system vendors should test systems well in advance of implementation to ensure a smooth transition.

Q26: *What is ICD-10-PCS and will I use in the outpatient setting?*

A: ICD-10-PCS is a code set designed to replace Volume 3 of ICD-9-CM for inpatient procedure reporting. It will be used by hospitals and payers. ICD-10-PCS is significantly different from Volume 3 and from CPT® codes and will require significant training for users. The system was designed by 3M Health Information Management (HIM) for CMS. ICD-10-PCS will not affect coding of physician or outpatient services. Physicians should be aware that documentation requirements under ICD-CM-PCS are quite different, so their impatient medical record documentation will be affected by this change. ICD-10-PCS has nearly 71,000 seven-digit alpha-numeric codes. Codes are selected from complex grids, based on the type of procedure performed, approach, body part, and other characteristics. The code system does not use medical terminology based on Latin or eponyms.

Q27: *Is there an ICD-10 (provider coding) book available for purchase?*

A: Many vendors are currently publishing ICD-10-CM code books. Ingenix is our training partner for ICD-10-CM/PCS training. AAPC offers a discount for the Ingenix books to our members. The codes will be updated yearly until implementation.

AAPC is working to provide a great deal of information to its membership to assist organizations in implementing this new system, and to use the new system once the compliance date approaches. Updates are posted to the AAPC ICD-10 website daily at www.aapc.com/ICD-10/. Please reference this website often for articles, information, and training options.

What is your most pressing ICD-10 question? Feel free to e-mail us and let us know.

Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P, is AAPC president and CEO.

Grass Roots: An Initiative for Local Chapter Growth

By Jill M. Young, CPC, CEDC, CIMC
Chair, AAPCCA Board of Directors

JoAnne Schneider of the Catholic University of America wrote *grass roots* "generally refers to local people working together to find solutions to problems in their communities." As members of AAPC local chapters, working together can make the coding communities more educated, informed groups and their meetings *the* place to be. As such, these members are proving certification through AAPC is the most valuable certification on the market.

As the governing body of local chapters, the AAPC Chapter Association (AAPCCA) has a responsibility to support our chapters' growth and success. And as the 2010-2011 AAPCCA board of directors' chair, I am pleased to announce Grass Roots — an initiative to work with local chapters at a grass roots level.

Local chapters of AAPC have an important role. As stated in the *Local Chapter Handbook*, one of the missions of these community-oriented groups is to promote and expand the medical coding profession. Numerous and far-reaching changes will make AAPC members a more valuable commodity in the next five years, most notably because of changes to national health care and the implementation of ICD-10. Certified AAPC coders, all 64,000+ strong, are a powerful force that will play an important role in those changes.

Local chapters are the support system of AAPC members. Those who participate in their local chapters are afforded a wide array of benefits:

- **Education** - both continuing and informative about new processes such as ICD-10.
- **Networking** - with members and others who attend meetings. The local chapter's geographic assignment of members inherently creates a diverse group. This frequently untapped resource gives participants in local chapter meetings a built-in source of information. For example, many chapters have members who work for insurance payers and access to these individuals is invaluable for many coders when gathering information and solving problems.
- **Friendships** - easily made when you have the knowledgebase all certified coders have. This commonality brings and holds together this diverse group known as a local chapter.

Local chapter success is not certain. Whether a chapter regularly sees 100 attendees at their meetings or if it struggles with only five to 10 members, each chapter is important to its members. There are chapters closing each year for a lack of leadership, interest, or cohesiveness. Luckily, new chapters open at a rate greater. As AAPC membership has grown to more than 95,000 members, local chapters are important as ever in meeting the needs of its members.

Identify Accomplishments for Chapter Success

How do you create a successful chapter and what allows a chapter the longevity to keep fostering success each year? There are many things contributing to this, but this is not a one-size-fits-all solution. We continue working to identify more solutions and to make these ideas, tips, and information part of a chapter's success.

The first part of this Grass Roots initiative is identifying success. I need you, local chapter members and officers (both past and present), to contact me with your success stories (YoungMedConsult@aol.com). For example, many chapters struggle to get speakers for their meetings. Four years ago I sent an e-mail to the regional office of the Office of Inspector General (OIG) and asked if they could send a speaker to a meeting I was planning. It took several e-mails to get to the correct person, but with patience and follow-up (and more follow-up) we had two gentlemen come to our meeting from 150 miles away. The information they shared was invaluable and their contact information is a great networking resource. Amazingly, they did not ask for any reimbursement for their travel; and, because of department policy, they could not accept the $25 gift cards we offered as a token of gratitude.

I need you, local chapter members and officers (both past and present), to contact me with your success stories.

Success Means Sharing Information

Finding and sharing invaluable information is the second part of the Grass Roots initiative. A new method the board will use to pass this information to chapters is through regional conference calls, hosted by AAPCCA regional board members. With this method leaders can call in and share ideas and information in a peer-to-peer format. These calls will be set up with a toll-free line for current local chapter officers. Our hope is to have monthly calls for each region. To find out who your regional representatives are, click the Contact Us link at the bottom of the main AAPC website (www.aapc.com) and select the Chapter Association Board link to the left. If you are a chapter officer, contact your regional representative today for information on when your call will be scheduled or check the Local Chapter Officer Forum.

As members and leaders, the success of the more than 450 AAPC local chapters is in our hands. AAPCCA is committed to helping local chapters succeed. By meeting the needs of AAPC members, local chapters can't help but succeed.

As the year progresses, the AAPCCA will continue in its Grass Roots efforts in other ways. Watch for them.

Jill M. Young, CPC, CEDC, CIMC, is principle of Young Medical Consulting, LLC. She has over 30 years of medical experience including a diverse background in all areas of medicine, from clinical to billing to physician specialties. Her comments and opinions can be seen in publications, audio conferences and at live educational conferences in several venues. She is one of the original members of the AAPCCA board of directors.

APPRENTICE

Coders Can Pay for Coding Mistake$

Understand the risks if you miscode.

By Michelle A. Dick

When claims for provider services aren't coded and billed properly, financial liability often falls on the provider. What happens when the coder or biller is to blame for sloppy coding or claims processing? Do coders need to pay?

Individual Liability for Fraudulent Billing

The Federal False Claims Act (FCA) imposes liability on any "person" who knowingly submits a false claim to the government for payment or who "conspires" to submit a false claim for payment. **Robert Pelaia, Esq., CPC,** of the AAPC Legal Advisory Board said, "The FCA can be used as an enforcement tool against anyone who 'causes' a false claim to be submitted. That could include coders who 'knowingly' cause false claim submission" and individuals who participate in fraudulent submissions, if those individuals are part of the actions that resulted in the false claim. This can include individuals who are responsible for "preparing, computing, calculating and submitting to Medicare claims for" medical services provided by a physician. For example, the United States vs. Cabrera-Diaz and Arbona, 106 F.Supp.2d 234,242 (D. P.R. 2000).

In the Arbona case, Dr. Manual A. Cabrera-Diaz, an anesthesiologist, falsely submitted over $400,000 in Medicare billings in 1994 and 1995. His "billing secretary," Esther Arbona, prepared and submitted Dr. Cabrera-Diaz's claims. The U.S. District Court entered a civil judgment against both Dr. Cabrera-Diaz and Ms. Arbona for $1.3 million and found that they were "jointly and severally liable," which means that the total amount of the judgment could be collected from either of them.

As for the FCA being used as an enforcement tool against false claim submissions, Pelaia said, "there are a lot of examples of this in the American Health Lawyers Association (AHLA)/AAPC book, *Deciphering Codes: Fraud & Abuse for Coders and Coding Insights for Healthcare Lawyers* to be released this summer."

Resource tip: *Deciphering Codes: Fraud & Abuse for Coders and Coding Insights for Healthcare Lawyers* is designed to help coders and attorneys understand and navigate health care coding and the law. It discusses why proper coding is essential for health care facilities and professionals, coding sources (CPT®, ICD-9, HCPCS Level II, legal implications of improper coding, applicable fraud and abuse statutes and regulations, including Civil Monetary Penalties Law (CMPL), FCA, the Anti-Kickback Statute (AKS), and the Stark Law. There is also specialty-specific setting guidance. The book stresses the importance of a detailed compliance plan for coding and discusses cases brought by federal and state governments against health care providers for improper coding. You can purchase the book with a searchable CD at www.aapc.com/onlinestore/vendor-book-store/index.aspx.

Can a Coder be Fined Under FCA?

AAPC Legal Advisory Board member **Michael Miscoe Esq, CPC, CASCC, CUC, CCPC, CHCC, CRA,** said, "No doubt, FCA money penalties can be levied against coders, but I have never seen a 'fine' or penalty levied against a *certified* coder." He added, "I haven't found a reported case where a third-party billing service was the target of a False Claims Act prosecution." Miscoe has seen, however, "one or two notable cases brought against consultants based on the 'caused a false claim to be submitted' theory of FCA liability but the vast majority of cases go against the facility or the physician." He said, "It is possible, however, for coders to be targeted and in such cases, the lack of resources to mount a defense usually causes some form of settlement that would escape national reporting."

"The only fines I am aware of are not fines at all but are civil money penalties authorized under federal statute," said Miscoe. "There is a possibility of similar money penalties for fraudulent conduct under state false claims statutes.

Respected Billing Employee Embezzles From Doctors

An extreme case of criminal activity from a medical billing employee happened in New Port Richey, Fla. Police detectives arrested a 52-year-old medical billing specialist, Catherine Yount, for swindling more than $200,000 from two doctors. Between 2006 and 2009, she deposited insurance checks into her own bank account instead of her employers'. She stole 99 checks totaling $157,031.87 from River's Edge Pediatrics in New Port Richey and $53,710.06 from cardiothoracic surgeon Dr. Michael Wahl. In both cases, Yount forged endorsement signatures on insurance checks, and then deposited them into her own account, local authorities said. "She was well-respected by a number of physicians and she was given great latitude and used it to put money in her own account," Capt. Jeffrey Harrington said.

"For a coder to be charged with fraudulent conduct let alone have a civil money penalty directed at them is essentially unprecedented except where the 'coder' is the spouse of the physician and/or was a financial beneficiary of the conduct.

"I have paid attention to the cases for years for evidence of a *certified* coder being implicated as a co-conspirator in a FCA case but I have not seen it yet," said Miscoe.

When Coders Are Fined by Their Employer

Nancy Reading, RN, BS, CPC, CPC-I, said some coding companies will take "recoupment from coders for mistakes … but these employees are usually subcontractors and this is a matter of contract." She added, "I am not certain how this could be done in a full-time employment situation legally."

Miscoe agrees that it may be a matter of contract if a coder is fined by their employer. He said that if there "is a contractual 'fine' embedded in their contract with the hospital for errors leading to post payment recovery," it's possible.

Dorothy Steed, CPC-H, CHCC, CPC-I, CPUM, CPUR, CPHM, CCS-P, CEMC, CFPC, ACS-OP, RCC, RMC, PCS, FCS, CPAR, CPMA, said it could happen in the hospital setting, "If a hospital is the target of a RAC audit, the attending physician (and other MD) notes may be requested to support or discount hospital coding/billing, although the MD was not the target of the investigation." She continued, "If a hospital must defend the audit, the skills of the coder will likely be closely scrutinized." For example, "If the coder has coded CC/MCC to raise the reimbursement based upon implications rather than absolute statements by the physician, leading to significant payback," Steed said, fines could be imposed. A fine "depends upon the specific employment arrangement."

"Hospital coders are expected to meet accuracy standards usually in the mid-90 percent range." Steed added, "Those who frequently fall below are usually subject to performance evaluation penalties or possible removal from the position—the 'fine' can take several forms."

Debra A. Mitchell, MSPH, CPC-H, has seen coders penalized for sloppy coding firsthand. "I have had participants come to me [in confidence] at seminars to report that they have been fined and it is not pleasant," she said.

Mitchell recalls reading about cases where coders have been fined but "the dollar amount was not revealed."

"I have read other resources that state penalties are in the millions," Mitchell said.

Protect Yourself From Monetary Liability

Read the fine print before you sign any contracts with employers to be sure there aren't any embedded financial penalties within.

To protect yourself from coding error fines you "should always code from the documentation and follow the coding guidelines," Mitchell said.

"As a coder, you should not append any code to a claim that is not supported by the documentation. If you make a mistake then it is just that, a mistake." Mitchell added, " If on a regular basis you assign the wrong codes because maybe you code from memory or you use a cheat sheet or you code from a superbill, then you are responsible for that code and it was not a mistake—it was intentionally applied."

[Michelle A. Dick is senior editor at AAPC]

Everybody Pays for Improper Coding

Although it's usually the providers who are held accountable, coders also may pay a price.

By Julie Chicoine, Esq., RN, CPC

I constantly hear coders expressing concern about personal liability for coding and billing issues. At the same time, U.S. Department of Health & Human Services (HHS) is taking a more proactive role for reviewing, paying, and monitoring Medicare reimbursements in the context of program integrity. In addition to the Office of Inspector General (OIG), the prime fraud and abuse overseer, other federal program integrity contractors and state enforcement agencies, have implemented initiatives to detect and investigate health care providers who submit false claims. Scrutiny is only going to get worse, but I think the outcome will be repayment or no payment and not necessarily enforcement actions.

The OIG's compliance program guidance for physicians advises to fully document their services and implement compliance programs to reduce coding errors and, ultimately, financial risk. The OIG's guidance redefined the term "erroneous claims" to assure physicians that the OIG is not looking for enforcement actions against practices for innocent billing mistakes. A pattern of submitting erroneous claims, however, may initiate an investigation. For example, episodic and isolated coding mistakes are not targeted, but continued misapplication of coding and billing rules either because the coding professional is cutting corners on accepted practices (i.e., coding standard only from documentation) or not keeping up to date (i.e., continuing education), can lead to an OIG enforcement action. This being said, ultimately, liability falls to the provider whose National Provider Identifier (NPI) the service was billed under and not the coder directly.

If such were the case, I could see the provider going after the coder for repayment after settling with the government. Given the high stakes with fraud and abuse liability, I could also see employers auditing coders for accuracy and taking mistakes out of the coder's pocket.

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