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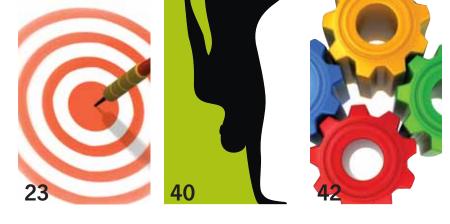












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On the Cover: 2010 Chapter of the Year, Columbia, S.C., stands with pride on the grounds of Richland Medical Park. Cover photo by Rachel Browne (www.rachelbrownephotography.com).



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Keep Current at AAPC

ou are probably surprised to see me in my former president/CEO position. I am, as well. Events can happen quickly and as a result, my role at AAPC changed quickly. Gratefully, it's a role I believe I know how to do.

Thank you Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CEMC, CPMA, COB-GC, CPCD, CCS-P, for your contributions to AAPC for the past year and a half. They are appreciated.

Remarkable Members

Congratulations, Maryann Palmeter, CPC, CENTC, for being our 2010 Member of the Year and Columbia S.C. for being our 2010 Chapter of the Year. Thank you both for appearing on our May and June *Coding Edge* covers, respectively. These honors are well earned and deserved. You are the best of our 100,000 plus members and 460 chapters who continue to educate, mentor, and assist members in a way that cannot be done on the national level.

AAPC Is on Top of Your Coding Needs

Let me bring everyone up to speed on hot topics at AAPC:

ICD-10

We continue to develop curriculum to help every health care person implement and/or code the new code set. For those involved or who should be involved in implementation, now is the time to be trained on what you need to know and how to accomplish it. We have short, fundamental ICD-10 information available to teach those who want to know about ICD-10, but not in detail. We can help physicians learn ICD-10 documentation requirements. We will have both general and specialized code set training, as well. We continue to encourage members to wait to begin code set training until the Oct.

1, 2013 deadline draws closer, rather than now, so the codes will be fresh and not forgotten. This will save you time and money. Rhonda Buckholtz, CPC, CPC-I, CPMA, CGSC, CPEDC, COBGC, CENTC, is leading AAPC's ICD-10 training effort. She has Kim Reid, CPC, CPMA, CPC-I, CEMC, Betty Johnson, CPC, CPC-H, CPMA, CPC-I, CPCD, and Michael Jordan (not the basketball player) on her team, plus a number of other expert members.

Educational Events

We hold live webinars on Wednesdays at 1 p.m. EST. If you can't listen to our webinars live, we provide the option to download and listen to them at your leisure. We also have two half-day workshops left on our schedule: "Modifiers - The Rest of the Story" by Jennifer Swindle RHIT, CPC, CPMA, CEMC, CFPC, CCS-P, CCP, in August and "RACs, MRACs, MICs and ZPICs - What Codes are Being Targeted Now?" by Christopher A. Parrella, JD, CHC, CPC, CPCO, in November. In September, we have a great regional conference planned in Nashville, Tenn. at the Gaylord Hotel (not during flood season).

2012 Coding Books

Our code set books are priced even lower than last year.

Online Conveniences

We have brought more membership conveniences to your fingertips. For example: more inexpensive, online exam help for students; a completely rebuilt Professional Medical Coding Curriculum (PMCC) for 2011; an ICD-10 tracker to help you prepare for ICD-10; continued decrease of email sent to you; and a new easy-to-use *Medical Office Compliance Toolkit*, which enables practices to build a complete compliance plan within hours.



We'll continue to serve our members with fast, helpful, and quality services.

As always, if you need to get hold of me directly, send me an email via the "Talk to Reed" link on the AAPC website.

Your friend,

Reed E. Pew Chairman and CEO

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Coding News



Bilateral Chemodernervation Coding Non-covered

On March 18, Medicare released *Medlearn Matters* article MM7319 Revised, announcing the April 1 update to the 2011 Medicare Physician Fee Schedule Database (www.cms.gov/MLNMattersArticles/Downloads/MM7319.pdf). Included in the update are "indicator changes" for seven CPT° codes.

Perhaps most significantly, Medicare has revised the bilateral surgery indicator for chemodenervation codes 64613 Chemodenervation of muscle(s); neck muscle(s) (e.g., for spasmodic torticollis, spasmodic dysphonia) and 64614 Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s) (e.g., for dystonia, cerebral palsy, multiple sclerosis). In the past, these codes were assigned a "1" bilateral surgery indicator, which meant that a 150 percent payment adjustment applied when either procedure was performed bilaterally. Beginning April 1, both 64613 and 64614 have a "2" bilateral indicator, which means, "150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure," the Centers for Medicare & Medicaid Services (CMS) states in the transmittal.

In a nutshell: Medicare now asserts that relative value units (RVUs) assigned to 64613 and 64614 assume that these are inherently bilateral procedures.

In the past, if the provider had injected botulinum toxin into bilateral anatomic sites, such as the right and left upper extremities, you would report the appropriate code with modifier 50 *Bilateral procedure* appended (e.g., 64614-50). Now, the same procedure would be reported using the code only, with no modifier (e.g., 64614). In contrast, if the provider injects only one side, you would report a reduced service (e.g., 64614-52), rather than the code without a modifier.

Results: Expect lower payment from Medicare for chemodenervation injections (approximately \$80 less for bilateral injections). You also should review your contracts with non-Medicare payers to be sure that you continue to report chemodenervation per the specific payer's requirements.

Additional "indicator" updates in the fee schedule, effective April 1, include:

31579 Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy now has a 0-day global period

92511 Nasopharyngoscopy with endoscope (separate procedure) now has a 0-day global period

57155 Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy now has a cosurgery indicator of "2" (Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.)

93464-26 Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)-Professional component) now has a multiple surgery indicator of "0" (No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.)

77071 Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated has been given a bilateral surgery indicator of "2" (150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.)

Is Your Power Mobility Device Documentation Up to Par?

If your physician, physician assistant, nurse practitioner, or clinical nurse specialist treats patients and/or prescribes power mobility devices (PMDs) for Medicare beneficiaries, be aware of the documentation requirements listed in CMS' "Power Mobility Device Face-to-Face Examination Checklist" (MLN Matters® article SE1112). Durable Medical Equipment (DME) suppliers who submit claims to DME Medicare administrative contractors (DME MACs) for PMDs should read this Special Edition (SE) MLN Matters, as well.

Besides listing the requirements, CMS provides a sample checklist for the PMD examination that can help get your claims paid when documented correctly.

For the complete checklist and examples of acceptable documentation, see SE *MLN Matters*® SE1112 (www.cms.gov/MLNMattersArticles/Downloads/SE1112.pdf) on the CMS website.



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Conference Recharges Members and Governing Bodies

his past April, AAPC held its 19th annual National Conference in beautiful Long Beach, Calif. After meeting and speaking with many attending members and hearing all the positive feedback the National Advisory Board (NAB) received post conference, I know I'm not alone in saying that this year's conference was one of the best we've had to date. I sincerely hope all in attendance enjoyed increasing their knowledge- and network-base, and arrived safely back home with renewed vigor for our profession.

Coding Electricity Fills Hearts

As always, I returned home from conference recharged, and reminded of why this organization has a thriving membership who are the best at supporting each other. That reminder was more prevalent than ever this year. Members committed to enriching their knowledge attended a wealth of seminars; and despite sore backs and feet, there was an abundance of excitement, smiling faces, and heartwarming hugs.

Collaborative Effort Strengthens Focus

While attending the conference, NAB President-elect, David B. Dunn, MD, FACS, CPC-H, CIRCC, CCC, CCS, RCC, and I were given the opportunity to meet with newly appointed AAPC Chapter Association (AAPCCA) Chair Melissa Brown, RHIA, CPC, CPC-I, CFPC, and Vice Chair Angela Jordan, CPC. The two boards, NAB and AAPCCA, sat down to discuss how we will work together over the next two years to support AAPC membership. Although the purpose of both boards is to work conscientiously to support the members, our mission statements somewhat differ.

AAPCCA's Mission Is **Empowering Local Chapters**

The AAPCCA is chiefly responsible for cre-

ating, supporting, and empowering each local chapters' efforts, and function to support the AAPC's mission of "Upholding a Higher Standard." The AAPCCA also provides local chapters with direction and advice and creates policy, rules, and regulations to assist local chapters in functioning in a manner that benefits its members and AAPC. In essence, this board, with its friendly and approachable manner, is the coach and cheerleader of membership, and the two ladies at its helm humbly embody the essence of AAPCCA.

NAB's Business Is Advising AAPC for Membership

The NAB supports AAPC membership by bringing coding-related issues, health care trends, and member needs and concerns to the attention of the national office. To stay on top of these issues the NAB writes articles and speaks at local chapters and health care-related conferences on coding and billing subjects. As Angela so gleefully pointed out to me during our first meeting, NAB members are the suit wearers with the "all business" demeanor at national conference.

Although I don't totally agree with Angela's assessment (I'm not sure my demeanor is "all business" all the time, but I do like my suits!), we all agreed that both boards sincerely held the highest regard for AAPC members.

Two Boards Working for You

During the next two years, Dr. Dunn and I will be working with Melissa, Angela, and the AAPCCA board to find ways to jointly serve and support our members. To fully support members in our rapidly changing health care environment will take both cooperation and communication between these boards. While the NAB relies on the AAPCCA's close chapter and member association to identify and relay issues that may



affect AAPC and its entire membership, the AAPCCA relies on the NAB's support to strengthen local chapters and fulfill their needs as the health care industry undergoes changes that may impact members.

As Melissa said eloquently while summarizing the intent of both boards, "The bottom line common goal is to make the AAPC the best it can be for the membership."

On behalf of the entire NAB, we look forward to working with AAPCCA to serve AAPC and its members.

Best Wishes,

Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P President, National Advisory Board

Cynthiad Stewart

Minimum Reporting Time for 99291 Is 30 Minutes

April's *Coding Edge*, "The Fundamentals of Time," page 26, states that the minimum required time to report 99291 is 31 minutes. Please confirm this number: The CPT® manual states 30 minutes.

Rebecca Davis, CPC

You are correct: The minimum time required to report the initial critical care code 99291 Evaluation and management of the critically ill or critically injured patient; first 30-74 minutes is 30 minutes, rather than 31 minutes. Critical care services of fewer than 30 minutes are not reported separately. As correctly reported in the article, at least 75 minutes of critical care must be documented to report 99291 and +99292 Evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service).

Per CPT°, a unit of time is attained when the midpoint is passed. As an example, prolonged service code 99354 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service) specifies "first hour" of prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service. This means you may not report 99354 until at least 30 minutes (the midpoint) is passed. CPT° allows you to report 99354 for 30-74 minutes of prolonged care. At 75 minutes, you may add 99355 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for office or other outpatient Evaluation and *Management service*). Note that 75 minutes is 15 minutes beyond an hour (represented by 99354), and represents the midpoint for 99355, which applies per 30 minutes.

Helpful Advice for Apprentices

I want to thank *Coding Edge* editors and authors for the recent articles aimed at apprentices, particularly those on how to network well and ace a job interview.

While reading the Letter from the President and CEO column by **Deborah Grider**, **CPC**, **CPC-H**, **CPC-I**, **CPC-P**, **CEMC**, **CPMA**, **COBGC**, **CPCD**, **CCS-P**, in March's issue, regarding the importance of networking, I thought to myself, "Yeah, networking is important, but how do I go about doing it?" Not long after, I found **Lori Hendrix's**, **CPC**, **CPC-I**, **CPC-H**, **CIRCC**, **PCS**, **FCS**, article "Understand the Value of Networking," which explained several effective and valuable methods.

Another article I was very impressed with was **Melody Irvine's**, **CPC**, **CPMA**, **CEMC**, **CPC-I**, **CCS-P**, **CMRS**, "Eliminate the Interview Jitters." Instead of just offering interview advice that can

be found anywhere, the author went a step further and gave advice specific to people interviewing for a coding and/or billing position, which is extremely helpful.

It is truly gratifying to know that I'm a member of an organization that listens and attends to the needs of all its members, no matter what level of professional they may be. Thank you for all that you do!

Vanessa Marshall, CPC-A

Consider the Whole Record when Leveling E/M Services

Does medical decision-making (MDM) or medical necessity drive evaluation and management (E/M) code selection? I've found conflicting answers.

For instance, "Accurately Score MDM in the ED" (January 2011) states, "MDM dictates the highest service level that may be reported, and history and physical exam documentation needed to support the choice." The 2010 Step by Step workbook I've been using backs up this statement.

In contrast, "The Driving Components of E/M Level Selection" (September 2009) advises, "Medical necessity, not MDM, drives E/M level selection." Likewise, I attended an "E/M Coding for MACs" workshop in October 2010, and my notes from the workshop state that MDM doesn't drive E/M code selection (I noted it twice).

When I work on scenarios, I get it right most of the time, but sometimes get stumped. Thanks for your help!

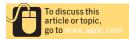
Victoria Chang, CPC-A

The Medicare Claims Processing Manual, section 30.6.1.A, stipulates, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code." This is an unambiguous statement, but it's not necessarily helpful to the coder, who generally is not in a position to second-guess a provider's clinical judgment as to what is medically necessary. (Imagine the response you'd get if you stood over the physician's shoulder during a patient evaluation and asked, "Are you sure about that, doc?)

Complete documentation will describe the nature of the patient encounter, and will provide the context for the services provided. Unless there are obvious gaps or other problems that require clarification, the coder must code from the medical record and assume the provider's clinical decisions regarding medical necessity are sound.

In the everyday struggle to assign E/M codes, MDM generally is the single best indicator of the E/M service level—but you cannot rely on it exclusively. If the E/M code requires three of three components, the lowest component—whether history, exam, or MDM—always determines the level of service.

When two of three components are necessary to support the level of service, there is no requirement, per CPT® or the Centers for Medicare & Medicaid Services (CMS), that MDM must be one of those



elements. The experienced coder knows to be cautious, however, if the levels of history and exam exceed the level of MDM. The history and exam should approximately equal the level of MDM because MDM influences the extent of history and exam that are required.

The use of templates (especially in an electronic health record (EHR)) may make it too easy for a provider to document more detail in the history and exam than is necessary, which can lead to upcoding. The Medicare Claims Processing Manual makes clear, "It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."

The lesson for the coder is: You must consider the whole service as documented. Looking first to MDM may get you started in the right direction, but by itself can determine nothing—and medical necessity remains the overarching criterion for all services.

Schedule IPPEs at the Right Time

I really enjoyed reading the article, "New Annual Wellness Visit: Boon or Trap?" by Stephen Spain, MD, FAAFP, CPC, in April's Coding Edge. I noticed, however, an error in the article on page 21.

Under the sub-heading, "Timing is Everything" the article states, "The IPPE also must take place within six months of the patient's Medicare eligibility." Based on Medicare Claims Processing Manual, chapter 12 - Physicians/Nonphysician Practitioners, 30.6.1.1 -Initial Preventive Physical Examination (IPPE); The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 extended the eligibility period for an IPPE from six to 12 months after an individual's Medicare Part Benrollment. A beneficiary is eligible for IPPE benefits identified in MIPPA if the IPPE is performed on or after Jan. 1, 2009 and within the 12-month period of his or her effective date of the initial enrollment in Medicare Part B.

Tonya B. Daye, CPC



ICD-10 code sets are all set to replace ICD 9 code sets effective Oct. 1, 2013. This transition is one of the major changes to come and will affect the entire Healthcare Industry. Make sure you and your staff are ready to cope with these changes and DO NOT lose any revenue during the transition. Our conferences and recordings will help your practice go through this transition and ensure that you get every single dollar you deserve from your claims.



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By G.J. Verhovshek, MA, CPC

Master Bundling Basics

Gain confidence in knowing when to bundle services and when to bill services separately.



Bundling occurs when a procedure or service with a unique CPT° or HCPCS Level II code is included as part of a "more extensive" procedure or service provided at the same time. Unbundling errors—coding separately for procedures that should have been bundled—are a frequent cause of claims denials and negative audit findings. Conversely, unnecessary bundling has a negative effect on reimbursement. Luckily, a little knowledge and an easy-to-access resource are all you need to master bundling basics.

How Bundling Works

A popular Chinese restaurant in my neighborhood offers a \$7.99 lunch special that includes an entrée, rice, an eggroll, and a medium drink. If you're not that hungry, you can order à la carte (for instance, just an eggroll and a drink), and the cashier will ring up each item separately.

Bundling in coding works the same way. For example, you may code separately for a diagnostic endoscopy provided "à la carte." But if diagnostic endoscopy precedes surgical endoscopy of the same type, per CPT® rules, the surgical scope includes the diagnostic scope. Only the surgical scope may be reported. As with the lunch special, one price covers everything.

Any designated "separate procedure" is bundled when provided with another service/procedure in the same anatomical location. For example, 29884 Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure) may be reported by itself to describe excision of adhesions. You would not, however, report (or be paid for) 29884 separately with another arthroscopic procedure in the same knee (e.g., 29877 Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)).

An example from the National Correct Coding Initiative (NCCI) Policy Manual (www.cms.gov/national-correctcodinited/) further illustrates the logic that supports bundling:

CPT° 36000 Introduction of needle or intracatheter, vein is integral to all nuclear medicine procedures requiring injection of a radiopharmaceutical into a vein. CPT° code 36000 is not separately reportable with these types of nuclear medicine procedures; however, CPT° code 36000

may be reported alone if the only service provided is the introduction of a needle into a vein.

Evaluation and management (E/M) services also may be bundled. All procedures, whether diagnostic or therapeutic, include an "inherent" E/M component, according to the Centers for Medicare & Medicaid Services (CMS) Transmittal 954 (www.cms.gov/MLNMattersArticles/downloads/MM5025.pdf). This inherent E/M is bundled into the procedure coding. For example, if the physician provides a cursory examination prior to a previously scheduled gastrointestinal (GI) endoscopy (43235 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen[s] by brushing or washing (separate procedure)), the exam is built into the endoscopy and is not reported separately.

The alert coder will recognize that there can be exceptions to bundling rules. For instance, per Transmittal 954, you may separately report an E/M service on the same day as another procedure if documentation substantiates that the E/M is "significant, separately identifiable ... [and] is above and beyond the usual pre- and post-operative work for the service." You also must append modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service to the E/M code to identify the service as distinct from other, same-day procedures/services.

NCCI: The Ultimate Bundling Reference

For Medicare payers (and many commercial payers), the end-all, be-all bundling resource is the NCCI. CMS updates the NCCI each quarter (Jan. 1, April 1, etc.), and posts the complete list of *edits*, as the bundled code pairs are called, as a free download at www.cms.gov/national-correctcodinited/. You also may purchase a subscription to NCCI, in electronic or paper format, from National Technical Information Service (NTIS) at www.ntis.gov/products/cci.aspx. Be sure that you always refer to the most upto-date version of NCCI when checking for code bundles. NCCI contains two kinds of edits. The first of these are the bundling edits, called "Column 1/Column 2" or "correct coding" edits (see the accompanying "NCCI Mutually Exclusive Edit Pairs" sidebar for a brief explanation of

For Medicare payers (and some commercial payers), the end-all, be-all bundling resource is the NCCI.

the second kind of NCCI edits). Codes listed in Column 2 normally are bundled to the code listed in Column 1, which is the "more extensive" procedure. Not every CPT* or HCPCS Level II code is subject to bundling edits, but a single Column 1 code may bundle dozens of Column 2 codes.

Consider this partial example of bundling edits (available in the CPT° Codes 20000-29999 - Column1/Column2 .zip file:

Column 1	Column 2
20205	20103¹
	202001
	24300¹

From this example, we learn that if the physician performs deep muscle biopsy (20205 *Biopsy, muscle; deep*), then wound exploration (20103 *Exploration of penetrating wound (separate procedure); neck*), superficial biopsy (20200 *Biopsy, muscle; superficial*), and manipulation under anesthesia (24300 *Manipulation, elbow, under anesthesia*) at the same location are included. Hypothetically, if a surgeon performs deep muscle biopsy of the left bicep and explores the wound at the same time, only the deep biopsy is reported.

Here's a second, edited example:

Column 1	Column 2
22551	622911
	62310°
	62311 ⁰

In this case, we see that cervical arthrodesis below C2 (22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2) includes injection for discography (62291 Injection procedure for discography, each level; cervical or thoracic) and single injection of diagnostic or therapeutic substances, not including neurolytic substances (62310 Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), or diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic and 62311 Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), or diagnostic or therapeutic substance(s) (including anesthetic, antispas-

modic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)) when performed at the same spinal location.

Know When NOT to Bundle

Code bundles aren't always absolute. A code that normally is bundled may be reported (and reimbursed) separately if both of the following conditions are met:

1. The NCCI code pair edit includes a "1" modifier indicator.

Look again at our NCCI code pair examples shown above. Notice that each Column 2 code includes a superscript "1" or "0." This number is called the modifier indicator. Those codes with a "0" modifier indicator may never be reported separately with the Column 1 code. For example, the 22551/62310 code pair edit has been assigned a "0" modifier indicator, so there are no circumstances under which you may report 62310 separately with 22551.

Those codes assigned a "1" modifier indicator may be reported and reimbursed separately from the Column 1 code, provided the second condition also is met.

2. The Column 2 procedure must be separate.

This can happen, for instance, if the two procedures occur at separate anatomic sites, or during separate patient encounters. For example, suppose the physician performs deep muscle biopsy (20205) on the left bicep, and performs wound exploration (20103) at a different location (such as the right thigh). Because 20205 has been assigned a modifier indicator of "1," and the two procedures occurred at separate locations, the procedures may be reported (and reimbursed) independently.

Modifiers Seal the Deal

When you unbundle an NCCI code pair edit, you must append a proper modifier to the Column 2 code. In our previous example for deep muscle biopsy on the left bicep and wound exploration on the right, proper coding is 20205, 20103-59.

Without a modifier, payers will automatically reject the Column 2 code, rendering it bundled and not separately payable. In the majority of cases, per the NCCI Policy Manual, modifier 59 *Distinct procedural service* "is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances." Here's another example for modifier 59 usage:

The Column 1/Column 2 code edit with Column 1 CPT° code 38221 *Bone marrow; biopsy, needle or trocar* and column two CPT° code 38220 *Bone marrow, aspiration only* includes two distinct pro-

NCCI Mutually Exclusive Edit Pairs

NCCI includes two types of edits. The first is bundling edits, which we focus on in the main article. The second is called "mutually exclusive edits." Mutually exclusive edits describe code pairs that would not reasonably be performed at the same session and anatomic location for the same patient. As explained by the NCCI Policy Manual, "An example of a mutually exclusive situation is the repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ. A second example is a service that can be reported as an 'initial' service or a 'subsequent' service. With the exception of drug administration services, the initial service and subsequent service cannot be reported at the same patient encounter."

Mutually exclusive code pairs are listed in two columns. As with bundling edits, mutually exclusive code pair edits may be bypassed if the edit includes a "1" modifier indicator, and if the procedures are performed at different anatomical sites or during separate patient encounters (for example, if a procedure is provided on contralateral structures, such as the left and right eye, or left and right knee, etc.). As with bundling edits, you must append an appropriate modifier (usually modifier 59) to the Column 2 code to designate the procedures as separate and distinct. Documentation must support separate coding for the procedures.

cedures when performed at separate anatomic sites or separate patient encounters. In these circumstances, it would be acceptable to use modifier 59; however, if both 38221 and 38220 are performed through the same skin incision at the same patient encounter, modifier 59 should *NOT* be used.

When reporting a significant, separately identifiable E/M service on the same day as a procedure, you should append modifier 25 to an E/M that accompanies a minor procedure (one with 0, 10, or "XXX" global period designation); or modifier 57 *Decision for surgery* to an E/M service that accompanies a major procedure (one with a 90-day global period).

Learn more: For additional information on applying modifiers 25 and 57, see "Wisely Choose Between Modifier 25 and Modifier 57," September 2010 *Coding Edge*, pages 22-24.

The Bottom Line

Bundled code pairs are not rare. The NCCI contains thousands upon thousands of bundling edits (22551, alone, bundles over 100 codes). Specialized coding and billing software will alert you to possible bundling edits, but remember: Eternal vigilance is the price of proper coding.

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

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Brush Up on A&P When Coding Fractures

Understand anatomy and pathophysiology

eveloping a better understanding of anatomy and pathophysiology (A&P) is one challenge you will face with ICD-10 implementation. The good news is brushing up on A&P, while seeing how it's applied in the *ICD-10-CM Official Guidelines for Coding and Reporting*, will make ICD-10 code assignment easier. As an example, let's look at fracture coding.

Locate Fractures

Traumatic fracture codes are found in chapter 19 of ICD-10-CM, "Injury, Poisoning and Certain Other Consequences of External Causes (S00-T98)." This chapter uses the S-section for coding different injuries related to single body regions, and the T-section to cover injuries to unspecified body regions, as well as codes for poisoning and certain other consequences of external causes.

Define Fractures

A bone fracture is a medical condition in which there is a break in the continuity of the bone. A bone fracture can be the result of high-force impact or stress, or trivial injury as a result of a medical condition that weaken the bones (e.g., osteoporosis, bone cancer, or osteogenesis imperfecta). The latter type of fracture is a pathologic fracture.

Codes for open fractures (where bone pierces the skin) contain a much higher level of specificity in ICD-10-CM, and further classification is needed for open fractures using the Gustilo open fracture classification system. This system, shown in the table below, identifies fractures as Type I, II, IIIA, IIIB, IIIC.

You must have an in-depth knowledge of fracture classification systems to assign fracture codes appropriately. For example, ICD-10-CM guidelines state, "A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced."

Gus	Gustilo Classification				
1	Low energy, wound less than 1 cm				
П	Wound greater than 1 cm with moderate soft tissue damage				
	High energy wound greater than 1 cm with extensive soft tissue damage				
	IIIA	Adequate soft tissue cover			
""	IIIB	Inadequate soft tissue cover			
	IIIC	Associated with arterial injury			

Fractures also require the use of a seventh character extender. The ICD-10-CM guidelines indicate:

Initial vs. Subsequent Encounter for Fractures

Traumatic fractures are coded using the appropriate 7th character extension for initial encounter (A, B, C) while the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

Fractures are coded using the appropriate 7th character extension for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are: cast change or removal, removal of external or internal fixation device, medication adjustment, and follow-up visits following fracture treatment.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate 7th character extensions for subsequent care with nonunion (K, M, N,) or subsequent care with malunion (P, Q, R).

The aftercare Z codes should not be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character.

Example

Tina suffered an open fracture of the left radius, type I with dislocation of the radioulnar joint dislocation.

ICD-10-CM coding:

\$52.372B Galeazzi's fracture of the left radius, initial encounter for open fracture type 1

The Galeazzi fracture is a fracture of the radius with dislocation of the distal radioulnar joint. It classically involves an isolated fracture of the junction of the distal third and middle third of the radius with associated subluxation or dislocation of the distal radioulnar joint; the injury disrupts the forearm axis joint.

You must have an in-depth knowledge of fracture classification systems to assign fracture codes appropriately.



Increase Specificity

The clavicle, or collarbone, is a long bone of short length that serves as a strut between the scapula and the sternum. It is the only long bone in body that lies horizontally. It makes up part of the shoulder and the pectoral girdle, and is palpable in all people. In people who have less fat in this region, the location of the bone is clearly visible where it creates a bulge in the skin.

Even though there is only one long bone for the clavicle, there are 24 coding choices in ICD-10-CM. These choices consist of four subcategories:

\$42.0 Fracture of clavicle

\$42.01 Fracture of sternal end of clavicle

\$42.02 Fracture of shaft of clavicle

\$42.03 Fracture of lateral end of clavicle

In each subcategory there are choices for displaced and non-displaced, as well as "laterality." A requirement for coding a clavicle fracture is the seventh character extension. Choices for this subcategory consist of:

A Initial encounter of closed fracture

B Initial encounter for open fracture

 $\textbf{D} \ \ \text{Subsequent encounter for fracture with routine healing}$

G Subsequent encounter for fracture with delayed healing

K Subsequent encounter for fracture with nonunion

 $\textbf{P} \ \ \text{Subsequent encounter for fracture with malunion}$

S Sequela

According to the American Academy of Family Physicians (AAFP), the anatomic site of the clavicle fracture is typically described using the Allman classification, which divides the clavicle into thirds. Group I (midshaft) fractures occur on the middle third of the clavicle; group II fractures on the lateral (distal) third; and group III fractures on the medial (proximal) third. Knowing these terms and classification can help in code assignment.

Example

Tim was seen in our office for pain with movement of his upper right arm and shoulder region. This pain has been present for about six weeks. He first noticed it after he was playing football at his family reunion three weeks ago, and has been treating himself with ibuprofen with no relief. In-office X-rays indicate a group II fracture of the right clavicle.

ICD-10-CM coding:

\$42.031A Displaced fracture of lateral end of right clavical, initial encounter

Review of the guidelines indicate that because this is the first time the patient is being seen for this condition, we would assign the seventh character extender of "A" for initial encounter. Because the physician did not indicate the fracture as non-displaced or displaced, the guidelines also indicate this encounter would be coded as displaced. Let's take this example through the patient's healing progression.

Example

Tim returned to our office three months later with complaints of intermittent pain of the right upper extremity. The physician determined it was a result of his previous fracture and took in-office X-rays that indicated a nonunion.

ICD-10-CM coding:

S42.031K Displaced fracture of the lateral end of the right clavicle, subsequent encounter for fracture with nonunion

Six months later, Tim returned for aftercare follow-up from his now-healed fracture. In ICD-10-CM, we code the aftercare with the same acute fracture code, with the seventh character extender for sequela. The coding would now look like:

\$42.031\$ Displaced fracture of the lateral end of the right clavicle, sequela

With working knowledge of anatomy and pathophysiology, you can appropriately assign codes in ICD-10. Refreshing your current skill set will be necessary so productivity will not suffer with ICD-10 implementation.

Sources

www.aafp.org/afp/2008/0101/p65.html

ICD-10-CM Official Guidelines for Coding and Reporting 2011

AAPC's Anatomy and Physiology for ICD-10-CM



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

Long Beach Bonds Attendees

Two individuals share their 2011 AAPC National Conference experience.

Anyone who has attended a national conference can speak firsthand to the excitement and camaraderie one feels when thousands of coding professionals from all over the country congregate to promote, learn about, and celebrate coding excellence. This first time national conference attendee, and AAPC Chapter Association (AAPCCA) board member brought home different conference experiences and insight; however, they share a common bond: a sense of belonging. Here are their stories.

Coding in Long Beach: Who Could Ask for More?

By Ken Camilleis, CPC, CPC-I, CMRS

Long Beach was my first national conference. I've attended AAPC regional conferences in Ko Olina, Oahu, Hawaii and Springfield, Mass., and I had a hankering to attend a national conference, as well. My wife, Marita Brooks Cable-Camilleis, CPC-A, who just passed her CPC° exam in December, attended with me.

We Hit the Hot Spots

Despite the cost and time involved in traveling nearly 3,000 miles from my home, I'm glad I went. Not only did my wife and I gain new coding-related experiences, we enjoyed considerable leisure time in the evenings, visiting and touring the Queen Mary, the Aquarium of the Pacific, and Belmont Shores. On Sunday morning, we accompanied five busloads of coders to Hollywood, stopping at Griffith Park, many shops, tourist attractions, and star landmarks on Hollywood Boulevard and surrounds. We also spent a couple of nights touring Long Beach

and dining with three other members of our local chapter.

It's a Small World

One of the things I found most beneficial to coders is the ability to network with other individuals from all over the country who share similar interests and goals. I met people from different coding specialties who could answer related ques-



tions or refer me to appropriate research. I even met a woman who now lives in Colorado but grew up in "the next town over" in Massachusetts, less than three miles from me. Her father built a recreation center I patronize every Saturday. This shows what a "small world" it is in the coding industry. I plan to keep in contact with my newfound

friends to share Long Beach experiences and coding knowledge.

Favorite Picks

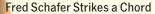
My favorite parts of the Long Beach conference were the speeches and breakout sessions related to ICD-10. Listening to Deborah Grider, CPC, CPC-H, CPC-P, CPMA, CPC-I, CEMC, COBGC, CPCD, address the crowd about the importance of preparing for ICD-10 was enlightening. The ICD-10 Boot Camp which Marita and I attended the first day, conducted by Kim Reid, CPC, CPC-I, CEMC, helped me gain insight into the ICD-10-CM coding processes.

As a certified and licensed Professional Medical Coding Curriculum (PMCC) instructor, I found the pre-conference "Teach the Teacher" program to be quite beneficial, not only for obtaining Con-

tinuing Teaching Units, but also for enhancing my current educational curriculum based on the AAPC's new "Medical Coding Training: CPC" program that was launched at the beginning of this year.

This being my first national, I was amazed at the quality of the numerous exhibits – 57 in all – and very impressed by the product dem-

os, contests, giveaways, and networking opportunities. Our local chapter group set up a table at the "Get to Know Your Local Chapter (G2KYLC)" event on Sunday afternoon. This was a great event, as were **Johnny Biscuit's** Code Watch videos, and related entertainment.



Above all, the session that really "struck a chord" with me was ironically not directly related to coding. I speak of **Fred Schafer's** Monday morning general session, "Striking Back at Mediocrity." As he talked about being prepared for "the storms of life," I thought not only of ICD-10 and coding from complex operative reports and other professional challenges, but also of myself,

my family, my students, and everyone else that has an impact on my well-being as a coder and otherwise. I was very impressed at how Mr. Schafer balanced seriousness and humor into this profound lecture.

For Marita and I, Long Beach was a vacation unlike any other. It started out as a business trip to enhance our coding careers and ended up being so much more.





Every Conference Has a Common Thread

By Jill Young, CPC, CEDC, CIMC, 2009-2010 AAPCCA Board of Directors

My first AAPC National Conference was in 2001 at the Rio in Las Vegas, which I attended with three of my colleagues. The four of us split up to attend as many different classes as possible and, in doing

so, were frequently separated for the entire day. This was precell phone days, so we had virtually no contact with each other. I remember that first-time attendee feeling I had after getting my registration packet and not knowing what to do next. One of the true pleasures of being at conference as a member of the AAPC Chapter Association (AAPCCA) Board of Directors is working at registration, helping that person on the other side of the counter who is alone and doesn't know what to expect or where to be. It is easy to explain the process of tracking conference CEUs and to show a map of the conference center, but these simple steps can help start a memorable week for that attendee. Many times that kind word is all it takes to kick-start a great experience.

I carried that desire to help throughout the entire conference. Here's where my conference story begins.

Sunday

Sunday morning's "Leadership Training" presented by the AAPCCA board was for those members looking to take on a

leadership role in their chapter. Nearly 400 signed up for this event. It started with "Name that Number," a game of AAPC and coding facts. When the MC's question asked how many employees worked in the Local Chapter Department at AAPC with Marti Johnson, the replies were 10, 20, and 30. The correct answer was actually four, and these overestimations showed me just how dedicated the Local Chapter Department is. Kudos to Emilie Nelson, Kay Boyce, Linda Litster, and Marti G. Johnson for your hard work that appears to be done by many, many more hands.

We also presented important information about proctoring and how to run a successful chapter meeting. In the beginning of the successful chapter meeting skit, I must admit, it was weird to be so rude walking into the room in character talking on my cell phone. It was also quite a site to see the stunned look on every-

one's face when I threw down someone else's ringing cell phone and stomped on it with my foot!

The G2KYLC was a great opportunity for chapters to take charge of a table and showcase their chapter in some way. It was a we some to see

27 chapters chant enthusiastically to get their "regional spirit" ready for Tuesday.

Monday

I spent Monday helping more people and assisting at registration. In between working, I found time to attend a session or two and sit down outside with friends and eat a great box lunch.



Tuesday

At the awards luncheon on Tuesday, the new Late Night Lunch format was a comedic hit with attendees. From on stage, I was pleased to see a sea of color. It was a wonderful show of regional spirit and a great way for people to meet new friends wearing the same color indicative of their region. Local chapters and members had a blast making more noise than I thought possible as Johnny Biscuit taunted the audience before a winner was announced for the Spirit Award. The green headdresses that lit up were creative and Region 4's win was well-deserved. There's always next year for us in Region 6—go purple!

Wednesday

I noticed that there weren't many people walking alone come the last day of conference. Many had found new friends and were smiling and talking as they walked together to classrooms. The day wore on and I saw sometimes tearful goodbyes as new friends separated with an exchange of business cards, a promise to call, and a final embrace before going their separate ways. I remember this part of my first conference, too.

Conference is an amazing time. I've learned so much at all of the conferences I've attended. I look forward to returning to the Rio (11 years later) for 2012's conference in Las Vegas; I know it will be just as exciting as the first.

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Michelle A. Dick is executive editor at AAPC

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By Vickie Balistreri, BA, RHIA, CPC, CPC-H, CCS, CCS-P, CCDS

Meet Documentation Criteria for Excisional Debridement



Don't let stringent requirements make you a RAC target

Mark Twain once said, "The difference between the right word and the almost right word is the difference between lightning and the lightning bug." I think this nicely summarizes the importance of using the "right words" to document excisional debridement.

Five Elements Complete Excisional Debridement Note

Documentation requirements to support excisional debridement coding are very stringent. Perhaps as a result, excisional debridement claims are targeted not only by recovery audit contractor (RAC) audits, but also by the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS).

Complete documentation for excisional debridement requires five elements:

- 1. A description of the procedure as "excisional"
- 2. A description of the instrument used to cut or excise the tissue (e.g., scissors, scalpel, curette)
- 3. A description of the tissue removed (e.g., necrotic, devitalized or non-viable)
- 4. The appearance and size of the wound (e.g., down to fresh bleeding tissue, 7 cm x 10 cm, etc.)
- 5. The depth of the debridement (e.g., to skin, fascia, subcutaneous tissue, muscle, or bone)

If any of these elements are missing, documentation does not meet the criteria for excisional debridement, according to RACs (see "RAC Reviewers Hit Hard on Debridement: Five Elements Must Be Documented," Report on Medicare Compliance, vol. 19, No. 6, Feb. 15). For example, using a sharp instrument does not necessarily indicate that an excisional debridement was performed. Documentation needs to describe the sharp debridement as a definite cutting away of devitalized tissue that includes cutting outside or beyond the wound margin.

Many hospitals and physicians have created templates (like the one shown to the right) to ensure that all of the elements are properly documented.

Selecting CPT® Codes

Prior to Jan. 1, 2011, excisional debridements were reported with code range 11040-11044. Effective Jan. 1, however, codes 11040-11041 were deleted. Instead, for debridement of skin only,

see 97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less and 97598 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure).

Codes describing excision debridement deeper than skin-only are organized by depth:

- Subcutaneous tissue (includes epidermis and dermis, if performed) – 11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less and 11045 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- Muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed) – 11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less and 11046 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

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Excisional Debridement Template nonexcisional Type of debridement (circle one) Size and appearance of wound debrided Removal of devitalized tissue description (necrotic, nonviable, etc.) Cutting instrument used (scalpel, forceps, scissors, etc.) (How deep did it go to get to pink, healthy tissue? Circle to deepest depth.) Depth of debridement subcutaneous skin

ICD-9 Debridement Procedure Coding

According to the *ICD-9-CM Official Guidelines for Coding and Reporting*, effective Oct. 1, 2010, "Excisional debridement involves surgical removal or cutting away, as opposed to a mechanical (brushing, scrubbing, washing) debridement. For coding purposes, excisional debridement is assigned to code 86.22. Non-excisional debridement is assigned to code 86.28."

A change from 86.22 Excisional debridement of wound, infection, or burn to 86.28 Nonexcisional debridement of wound, infection, or burn will make a significant difference in hospital reimbursement under Medicare severity diagnosis-related groups (MS-DRGs).

• Bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed) – 11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less and 11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Note that these codes are reported by area (sq cm), in addition to depth. For example, a 65-year-old patient with diabetes presents with a 5 cm x 4 cm ulceration (20 sq cm) involving the skin and subcutaneous tissue of the left heel. The physician examines the ulcerated area for size, depth, location, and staging. Using a scalpel, he excises (removes) the necrotic skin and subcutaneous tissues to the level of viable tissue, and then irrigates the wound.

Proper coding in this case is 11042. If the area of the wound was 30 sq cm (e.g., 5 cm x 6 cm), proper coding would be 11042, 11045.

excising devitalized tissue. Likewise, the Arobella Qoustic Wound Therapy System™ uses an ultrasonic assisted curette to mechanically debride wounds.

According to American Hospital Association's (AHA's) *Coding Clinic for ICD-9-CM*, second quarter 2004, debridement performed by physical therapists is generally nonexcisional. Debridement of the skin that is preparatory to further surgery, such as reduction of fracture, should not be coded as a separate procedure.

A CPT* example of nonexcisional debridement is 97602 Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session. This code would be used, for example, if a wound is cleaned, evaluated for size, depth, and evidence of ulceration or necrosis, hydrotherapy is used to soften and loosen the tissue, and dressing is applied.

Debridement of the skin that is preparatory to further surgery, such as reduction of fracture, should not be coded as a separate procedure.

Nonexcision Debridement Calls for Different Coding

Nonexcisional debridement is described as non-surgical because it does not involve cutting away or excising devitalized tissue. It is described as removal of devitalized tissue, necrosis, and slough by other methods, such as:

- Scrubbing
- Washing
- Water scalpel (jet)
- Irrigation (under pressure)

Examples of nonexcisional debridement are pulsed lavage, mechanical lavage, mechanical irrigation, high-pressure irrigation, etc. For instance, Versajet™ debridement is always considered nonsurgical, mechanical debridement because it does not involve cutting away or

Use E/M Codes for Nonsurgical Cleansing Without Debridement

When the service provided is only a nonsurgical cleansing of a wound without debridement, with or without the application of a surgical dressing, use the appropriate evaluation and management (E/M) code, not a debridement code.

For example, a patient is seen in the office for subsequent wound care. The wound is cleansed with topical ointment. No tissue is removed, and the wound dressing is changed. For this you would report an E/M service, as supported by the level of documentation (e.g., 9921x).

Vickie Balistreri, BA, RHIA, CPC, CPC-H, CCS, CCS-P, CCDS, is a health care consultant for JA Thomas & Associates-Clinical Documentation Improvement and has 26 years of health care coding and auditing experience. Balistreri is a former AAPC (NAB) member.



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By Jacqueline Baer, RN, MSN, CPC-H

Medical Necessity:

Why All the Denials?

Make sense of guidelines and be sure provider services are necessary.

s your provider or facility receiving multiple denials for claims that, according to the remittance advice from the payer, fail to show medical necessity? A clear understanding of Medicare guidelines, and what is required to show medical necessity, will help you make sense of the situation and ensure proper claims payment for your office.

Medical necessity is defined by the Centers for Medicare & Medicaid Services (CMS) under the Social Security Act, sec. 1862 [42 U.S.C 1395y]:

(a) Not withstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

What does that mean in plain English? Basically, CMS wants proof of why the patient required the service(s) to retain or regain his or her health.

For example, John Doe comes in to the hospital for a chest X-ray ordered by his physician with nothing but a requisition with a diagnosis of chronic obstructive pulmonary disease (COPD). As the facility providing the X-ray, the hospital is responsible for proving medical necessity. This case will be denied, however, because the diagnosis alone won't satisfy medical necessity requirements. CMS wants to know *why* the test is being performed, and *what* evidence exists to back it up.

"Suspected" Must Be Documented, but Not Coded

For years, CMS has said that in the outpatient setting you cannot use the terms: "probable," "likely," "rule out," or "suspect-

ed." Now, CMS wants you to document the diagnosis AND what the provider thinks is "probable," "likely," "rule out," or "suspected," along with the key clinical indicators. This does not mean you should code "probable," "likely," "rule out," or "suspected" conditions. This information should be documented only to support medical necessity.

To adjust the preceding example to support medical necessity, the physician could have written on the requisition: "DX: COPD; suspect exacerbation, wheezes bilaterally in all lung fields." The "suspect exacerbation" explains why the X-ray is medically necessary; and "wheezes bilaterally in all lung fields" explains what has led the provider to this conclusion. Do not code the exacerbation, however, unless it is confirmed by a subsequent service.

Solutions to Ensure Documented Medical Necessity

Getting claims paid requires teamwork. Physicians, coders, and billers must work together to ensure all the elements necessary for proper claims payment are in place. You might, for example:

Become familiar with your CMS contractor or fiscal intermediary (FI). Take advantage of all they offer on their websites, and sign up for automated email alerts for updates. Medicare builds guidelines into local coverage determinations (LCDs) and national coverage determinations (NCDs), which you can access on the Medicare Coverage Center website (www.cms.gov/center/coverage.asp). Your area's FI also has guidelines. Noridian, Highmark, and Trailblazer also have great websites where you

- can search for documentation requirements.
- Review all CMS widespread notifications. Don't just sign up for Part B because your provider or facility is an outpatient facility or physician office. Often, Medicare Part A notifications will apply to Part B.
- Make sure your coding books are up to date.
- Use resources provided to you as a member of your professional organizations, such as AAPC.
- Sit down with your provider and talk about denials. Research and have the facts ready. For instance, if you are getting denials on hemoglobin A1C testing, look at the *Medicare Benefits Policy Manual*, the medically unlikely edits tables, and any related LCDs and NCD to make sure you are familiar with how many tests are allowed.
- Conduct internal audits to be sure documentation supports treatment and testing.

Medical Necessity Is an Issue for All Payers, POS

To save money and make sure providers are compliant, major insurance companies have hired auditors to scrutinize claims. Recovery Audit Contractors (RACs) post medical necessity issues on their websites. To survive, providers and facilities will have to document medical necessity in every aspect of the treatment and testing of patients. This includes diagnostic tests, labs, procedures, and inpatient admissions.

Why inpatient admissions? Medical necessity has to be proven to admit a patient to the

hospital. The following is an example of an IP admission lacking medical necessity:

John Doe goes to the emergency room (ER) for chest pain. He has had this pain for two days intermittently. The chest pain radiates to the patients left arm. All vital signs are within normal limits. Cardiac enzymes are ordered and the first set comes back normal. In the ER the physician orders a chest X-ray on his patient—even though the patient recently had a chest X-ray. The physician does not document what he thinks is probable, likely, ruling out, or suspected. The patient has no clinical indicators for pulmonary issues. The physician decides to admit the patient to IP to do further testing as nothing is relieving the patient's chest pain. The patient is admitted with a diagnosis of chest pain, rule out myocardial infarction (MI). A hospitalist is assigned to follow the patient in the hospital. The patient is receiving all medications by mouth. Electrocardiograms (EKGs) come back with normal sinus rhythm and no ST elevations. The rest of the patient's cardiac enzymes are within normal limits and the patient's symptoms dissipate. The patient is discharged home the next morning with a diagnosis of atypical chest pain.

In this example, a chest X-ray was done in

the ER with no proven medical necessity (the patient had recently had a chest X-ray). The second issue is that the patient was admitted as an IP to the hospital, but should have been referred to observation. CMS states in Transmittal 107, Change Request (CR) 6492, "Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge." This care usually is provided in less than 24 hours, and no more than 48 hours.

The following example shows *proper* patient placement:

John Doe goes to the ER for chest pain. John Doe has had this pain for two days intermittently. The chest pain radiates to the patients left arm. All vital signs are within normal limits. Cardiac enzymes are ordered and the first set comes back normal. In the ER, the physician reviews a chest X-ray on his patient that he recently had done. He documents that he is ruling out mediastinal widening due to patient's history of hypertension. The physician

decides to do further testing because nothing is relieving the patient's chest pain. The patient is referred to observation with a diagnosis of chest pain, rule out MI. A hospitalist is assigned to follow the patient in the hospital. The patient is receiving all medications by mouth. He is treated with nitro and an aspirin, in addition to his regular blood pressure medication of Lisinopril and diuretics. EKGs come back with normal sinus rhythm and no ST elevations. The rest of the patient's cardiac enzymes are within normal limits and the patient's symptoms dissipate. The patient is discharged home the next morning with a diagnosis of atypical chest pain.

As always, education is the key to proper claims payment. Learning how to document medical necessity is just one more class in the grand scheme of things. The resources for learning this essential information are out there; it's up to you to put them to good use.



Jacqueline K. Baer, RN, MSN, CPC-H, is a corporate compliance auditor/coordinator for Yuma Regional Medical Center in Yuma, Ariz. She has more than 15 years of clinical experience, with over six years in clinical documentation and coding. She serves as the education of-

ficer for the AAPC Flagstaff, Ariz. Local Chapter.

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Capital Coders Emphasize Education

With education driving the Columbia, S.C. Local Chapter, it's no wonder its members won AAPC 2010 Chapter of the Year.



Front row (I-r): Debra Jones, president; Elizabeth Fogle, president-elect
Middle row (I-r): Margaret Banta, education officer; Belinda Inabinet, new member officer; Linda Wheaton, secretary (shared)

Last row (I-r): Lisa Duvall, treasurer; Janet Dunkerley, founder of chapter; Alexis Alia, chaplain; Deborah Rollison, secretary (shared) is not pictured

AAPC is proud to present the 2010 Chapter of the Year Award to the Columbia, South Carolina Local Chapter—better known as Capital Coders.

2010 President **Debra L. Jones**, **CPC**, said winning this award has been 10 years in the making. "We set a goal in 2001 to become the 'Chapter of the Year' winner. We took baby steps along the way, setting obtainable goals each year, hoping that one day we would be awarded such a prestigious award," Jones said. "Our chapter has (like most chapters) had its share of challenges throughout the years. As we achieved one goal and went on to the next, we celebrated each of those successes and set our sights on a higher goal for the next year."

Capital Coders' founder, Janet Dunkerley, CPC, CMC, CPC-I, said, "We have worked so long and hard for this honor, always going above and beyond, but never quite getting there. It was amazing to see all of our hard work pay off—big time! I am so happy and so proud of our members. They deserve this honor. They're the best!"

Look at All They Accomplished

Director of Local Chapter Support Marti Johnson said, "This chapter not only fulfilled the basic requirements to be a local chapter in good standing, but truly went above and beyond for their chapter members and the medical community."

To earn the award, according to Johnson, Capital Coders:

- Held review classes to help members get ready for their exam. They have four to six each year and offer the CPC° exam 12 times a year. Dunkerley is the PMCC instructor who conducts the class.
- Offered additional CEUs through an all-day seminar.
 Since 2003, the chapter has held an "Annual Spring Seminar" in March. They offer six to eight CEUs each year and feature speakers who are local Medicare carriers, doctors, and coders presenting on a variety of topics.
- Recognized newly certified chapter members on their accomplishments in passing the certification exam. Jones said, "Every quarter our chapter holds a 'pinning' ceremony in which the newly certified coders receive their CPC or CPC-H pin."
- Helped members find jobs. Capital Coders has helped their members gain internships with local businesses, often leading to permanent jobs.
- Were active with local colleges. To ensure their coding and billing curriculums were up to standards, the chapter aligned with Remington College, Southeastern, and Virginia College. The chapter also "speaks to the students to help them gain a better understanding of coding and billing and how to become a certified coder," according to Jones.
- Helped local charities. In 2010, Capital Coders presented Palmetto Health Children's Hospital and Sistercare of Columbia, S.C. each with a \$500 check. The chapter chooses one or more local charities each year, donating monies from their own budget as well as from chapter-led fundraisers.
- Showed gratitude to others. Feeling grateful for the success of the AAPC's Jacksonville National Conference in 2010, they sent a thank you letter to the mayor of the city.

Additionally, 2010 New Member Development Belinda Inabinet, CPC, CCC, said her chapter would "hold dual meetings at times," to accommodate members who couldn't attend during the standard monthly lunch hour meeting. The chapter also was responsible for establishing South Carolina's Coder's Day in May.

Striving to Educate to the Highest Level

Providing quality education has been a main focus for Capital Coders. **Emilie Nelson**, Local Chapter Event Approval, said that Columbia, S.C. "truly cares about each member and gives them the

quality education they deserve." The Columbia chapter has proved to the national office their commitment to provide educational and mentoring opportunities for members by aligning with two local colleges that offer coding and billing curriculum.

"We as a chapter want to be sure future coders and billers are provided with the correct learning tools and skills to succeed in this wonderful field we are part of," Jones said.

Providing CEUs to members also is an important part of local chapter meetings, and the Columbia chapter makes sure their education offerings cater to everyone's needs. 2010 Treasurer Lisa K. Duvall, CPC, CCS-P, said, "As a former education officer for the chapter and as the billing manager for a 45+ provider pediatric multi-specialty group, I am excited that the CEUs offered each month include a variety of specialties. The chapter continually strives to present timely and informative topics. Knowledgeable presenters ensure correct information is conveyed regarding their specialty and include coders, non-physician practitioners, as well as physicians."

2010 Secretary **Deborah Rollison**, **CPC**, said that Capital Coders worked hard last year "to ensure all the coders in their area continued to improve their skills and were able to obtain the knowledge needed to perform at their highest level possible." Rollison said they did this "by offering them a way to network with seasoned coders and possibly get internships to help them gain the experience they need as apprentices." The chapter communicates new coding concepts and job opportunities to members via a newsletter.

Welcoming All

Capital coders extend themselves to welcome new members. To do this, the chapter:

- sends new members and newly certified members a personal invitation to meetings via email.
- provides new members with directions to the meeting place, time, and speaker information.

- sends out a "member profile" questionnaire to be featured in their monthly newsletter.
- gives new members the new membership officer's business card with essential contact information in case of questions.
- does a roll call at meetings to identify new members and recognize newly certified members.

Compassion Calls for Extra Elected Officials

Columbia is one big family, and many members have formed long, lasting friendships. This bond led to a request from members to form another officer position of chaplain. The purpose of the chaplain is to help members share their successes and failures with each other. 2010 Education Officer Margaret Banta, CPC, said, "We were the first chapter to see the need for a new officer position. Many members of our local chapter were going through some trying times: health issues, family deployments, deaths, to name a few. We saw the need for compassion and thought not only would we sympathize and empathize with the members of our local chapter, but we'd also celebrate the good news as well—the congratulations for weddings, births, and passing exams. We now have a 'go to' person when a local chapter member is in need."

What's Next in Columbia's Future?

The chapter also has an executive board made up of current and past officers who meet every quarter to discuss what's next on the chapter's to-do list. That list continues to grow. One issue on the table is how the chapter can provide services to members who have a speech or hearing impairment. "We want all members to benefit from our meetings and seminars. We may have been awarded 2010 Chapter of the Year but we still have a lot of work to do to continue with growth for the chapter," Jones said.

Michelle A. Dick is executive editor at AAPC.



Their Commitment is Priceless

We asked a couple of well-known Capital Coders: "What do you like most about your chapter?" Here are their responses:

"The people there are just amazing. Everyone is willing to help each other; we have the 'pay it forward' mentality. We remind everyone of the time when they needed someone to proctor their exam or needed a mentor or someone to help them break into the field. Instead of trying to pay them back, we encourage our members to 'pay it forward' and help someone else out. It really does come back to you ten-fold, and the amazing feeling you get when you help others out—priceless!"

Capital Coders' founder Janet L. Dunkerley, CPC, CMC, CPC-I

"We are constantly looking for new ways to grow and connect with the health care community. One hot topic that was discussed at our April chapter meeting was the need to recruit physicians to become certified coders. If we can better communicate with the doctors and other health care providers, our practices would be more successful, not only financially but clinically ... We are moving towards creating an environment of cooperation and learning within our chapter through respecting each other's professional experiences."

2011 President Elizabeth Fogle, CPC

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By Melissa Brown, RHIA, CPC, CPC-I, CFPC, AAPCCA Board of Directors Chair

AAPCCA: Strong and Proud

Our mission is local chapter success.

Over the past 10 months, the AAPC Chapter Association (AAPC-CA) Board of Directors has solidified our internal structure and have become more outspoken about supporting and strengthening the chapters we serve.

The AAPCCA was formed as a legal registered entity to ensure chapters could remain non-profit. Our mission:

The AAPCCA, the governing board for the AAPC Local Chapters, was established to create, maintain, and sustain the infrastructure, through approachable and accountable representation, necessary to empower local chapters to function in support of the AAPC mission of "Upholding a Higher Standard."

A board of directors was needed to guide the collective group in a cohesive manner. Sixteen individuals were appointed to serve as the first board of directors. This group developed policies, bylaws, and processes and incorporated those messages into the *Local Chapter Handbook*.

Having established an infrastructure, the board now works on its intended purpose: serving local chapters. The national conference in Jacksonville was our most visible effort to date. Although you may have missed us as we roamed the convention center in our purple shirts, you couldn't have missed our orange hair, green headbands, and purple glow sticks as we helped energize our regions to show spirit and generate donations for Project AAPC (specifically for Nashville flood relief). That same spirit is what we all bring to the efforts of the board today.

Another national conference has come and gone. We're sure attendees will remember the women in purple shirts and their enthusiastic support! In case you missed us, however, we'd like to share some of our accomplishments this past year:

- collected over \$14,500 for Project AAPC during the conference in Jacksonville to help the American Red Cross assist with Nashville flood relief efforts. Over 60 local chapters and thousands of members contributed to the effort.
- contributed 14 articles to *Coding Edge* to help chapters and members learn and grow. Some of our topics included handbook clarification, making lasting impressions, how to become chapter of the year, mentoring, and coding issues.
- contributed more than 34 articles to industry publications to promote AAPC's message.
- visited more than 73 chapters to share information and answer questions.
- presented over 53 lectures at chapter meetings.
- presented over 24 seminar topics, including national and regional AAPC conferences.

- answered over 589 questions from chapter officers.
- approved the start of 52 new chapters.
- saved chapters from closing by providing support and encouragement.



- updated the *Local Chapter Handbook* to address current issues and technology.
- conducted surveys and addressed the dilemma facing the CPC-A population.
- put in over 1,200 hours of work to support the chapters by serving on various committees, including public relations, local chapter development, *Local Chapter Handbook*, and various task forces.
- provided the tools and resources to successfully run a local chapter, become mentors, and have fun doing it to a crowd of 300 participants during a leadership training session at the Long Beach conference.
- provided a way for over 28 chapters to share their ideas and success stories with attendees during the Get to Know Your Local Chapter event at conference. The AAPCCA table provided additional success kits and ideas that members could take back to their home chapters and implement.
- helped turn Project AAPC at the Long Beach conference into a dual focus for home and abroad. We generated an awareness of the homeland issue of hunger and collected over \$3,500 to give back to the communities through Feeding America. We also raised \$1,400 for Japan tsunami and flood relief to be presented to the American Red Cross.

In addition to board duties, every member of the board is an active participant in her local chapters. We work hard to support our chapters and communities and love every minute of it (okay, maybe not EVERY minute).

With that said, we'd like to introduce you to our new board, and we invite you to get to know your board members personally. We love to hear from our members and learn about what's happening in your chapter. The best way for chapters to grow is to share our success stories (and sometimes failures) so we can learn from each other.

Get to Know Your 2011-2012 AAPCCA Board of Directors

The AAPC Chapter Association (AAPCCA) Board of Directors is comprised of 16 certified AAPC members and one AAPC representative. Two board members represent each region of the country. New board members are selected on an annual basis.

Region 1 – Northeast



Susan Edwards, CPC

Medical Coder, Copley Hospital

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

Chapter affiliation: Newport, Vt.

Offices held: secretary, education officer, president-elect



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

Director of Reimbursement and Business Development, Gammarad Practice Management

Lashelle Bolton has 20 years of experience serving as a clinical and administrative professional, a certified coder, and coding instructor. She served as president of her chapter in 2009 and is president-elect. She is recognized as an expert in her field and has written and presented at various billing and coding seminars, both locally and nationally

Chapter affiliation: Upper Saddle River, N.J.

Offices held: president-elect, president



Region 2 – Atlantic

Meeting Coordinator Claire Bartkewicz, CPC-H

Manager of Outpatient Coding and Reimbursement, Bayshore Community Hospital

Claire Bartkewicz has worked at Bayshore Community Hospital for 25 years, first as a patient registrar in the emergency department (ED), and later in HIM. She attended her first coding class when CPT° was in its infancy, and went on to earn a Certified Professional Coder-Hospital (CPC-H°) credential. She now shares this knowledge by teaching at a local community college; and uses her registration background to manage the revenue cycles of outpatient coding and reimbursement. She also is co-founder of the annual New Jersey Coding and Billing Conference.

Chapter affiliation: Monmouth Ocean, N.J. Offices held: education officer, president



Robin Zink, CPC

Business Office Manager, Lancaster Orthopedic Group

Robin Zink has 26 years of experience in health care, working in various capacities within the physician practice and hospital settings. She received a CPC° certification in 2003. Previously serving as an officer of a local chapter, she was instrumental in helping to establish the Lancaster, Pa. chapter two years ago. It has since grown to more than 200 members. Zink enjoys mentoring and encouraging other coders, and is especially proud that her entire coding staff has received their CPC° certification. Her areas of expertise include revenue cycle management, coding, and regulatory compliance.

Chapter affiliation: Lancaster, Pa.

Offices held: president-elect, president

Region 3 - Mid-Atlantic

Treasurer Judy A. Wilson, CPC, CPC-H, CPC-P, CPC-I, CANPC

Business Administrator, Anesthesia Specialists

Judy Wilson has been an anesthesia medical coder/biller for over 27 years. For the past 17 years, she has been the business administrator for Anesthesia Specialists, a group of nine cardiac anesthesiologists who practice at Sentara Heart Hospital. Judy started the Virginia Beach chapter and continues to be an active participant. She teaches the Professional Medical Coding Curriculum (PMCC) at several locations in Tidewater, Va.; and enjoys helping others achieve their coding certification goals and offering continuing education opportunities.

Chapter affiliation: Virginia Beach, Va.

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

Lynn Keaton-Cockrell, CPC, CPC-H, CPC-I, CEMC

President, LCA Medical Consulting and HIM Director, Hickman Community Health Services

Lynn Keaton-Cockrell has more than 25 years of experience in the health care industry. Her goal is to provide quality information in a manner that is clinically and ethically compliant as she assists physicians with third-party payer audits (including recovery audit contractors (RAC) audits) at various stages of appeals. She provides PMCC training through Columbia State Community College, is the health information manager for Hickman Community Health Care Services, has provided coding workshops for the Tennessee Medical Association, and serves on the Cahaba Physician Outreach and Education Advisory Group as a representative for Tennessee.



Chapter affiliation: Columbia, Tenn. **Offices held:** president, president-elect, education officer

Region 4 – Southeast

Melissa Brown, RHIA, CPC, CPC-I, CFPC

Manager of Education and Reimbursement, University of Florida Jacksonville Physicians, Inc.

Melissa Brown has 19 years of experience in the health care industry. Her passion for researching complex coding queries and difficult reimbursement issues across diverse specialties makes her a valued resource for students and business partners. Her areas of expertise include fee analysis, budgeting, and the Physician Quality Reporting System (PQRS). In addition to coding-related topics, she enjoys presenting on teamwork and communication skills. Toastmasters International awarded her its highest honor, Distinguished Toastmaster. Her communication skills make her a sought-after speaker at seminars and conventions. Brown is co-director of the annual "Coding on the River" convention in Jacksonville, Fla.



Chapter affiliation: Jacksonville River City, Fla. **Offices held:** treasurer, president-elect, president

Melissa Corral, CPC

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

Melissa Corral has worked for Health Partners, a local preferred provider organization (PPO) network in Northeast Georgia, since 2003. With a bachelor's degree from Brenau University in Conflict Resolution and Legal Studies, she began as provider relations representative and excelled in those areas. As opportunities opened up, she took on additional contracting responsibilities. In 2006, Corral received CPC° certification and has remained an active participant in her local chapter. Besides holding chapter offices, she has assisted with audio-visual (AV) equipment for local chapter meetings, seminars, and teleconferences.



Chapter affiliation: Gainesville, Ga. **Offices held:** education officer, secretary

Region 5 – Southwest



Lynn Ring, CPC, CPC-I, CCS, CCS-P

Coding, Billing, and Compliance, Moffitt Cancer Center

Lynn Ring has more than 30 years of medical coding and billing experience. She has been involved in every aspect of coding from statistics and research to reimbursement and compliance. She has been a PMCC instructor since 2002 and has taught and certified countless new coders. With a recent move to Tampa, Fla., she is starting anew with coding, billing, and compliance for Moffitt Cancer Center with over 250 providers.

Chapter affiliation: Brandon, Fla. and Winston, N.C. (Piedmont Professional Coders)

Offices held: president, president-elect, secretary



Secretary Wendy Grant, CPC

Accounts Receivable Manager, Health Management Associates

Since 1977, Grant has worked in the coding arena. In her role as accounts receivable manager for Health Management Associates (HMA), Grant analyzes physicians' coding trends, mentors and teaches the coding and business office personnel via webinar presentations, and provides denial analysis and management to maximize revenue and turn denials into cash for HMA's enterprises in Tennessee, Oklahoma, Missouri, and Washington. Grant says, "Coding is not just about abstracting and auditing—it's about using your coding expertise to overturn payer denials and communicate claim appeals correctly."

Chapter affiliation: Little Rock, Ark.

Offices held: education officer, president-elect





Freda Brinson, CPC, CPC-H, CEMC

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

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

Chapter affiliation: Savannah, Ga.

Offices held: education officer, president



Barbara Fontaine, CPC

Business Office Supervisor, Mid County Orthopaedic Surgery and Sports Medicine

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

Chapter affiliation: St. Louis Professional Coders, St. Louis West Local Chapter

Offices held: education officer, president







Region 7 - Mountain/Plains

Vice Chair Angela Jordan, CPC

Manager of Coding and Compliance, EvolveMD by WHN in Lenexa, KS

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

Chapter affiliation: Kansas City, Mo.

Offices held: education officer, president-elect, president



Donna Nugteren, CPC, CEMC

Manager of Billing and Revenue Cycle Services, Avera Medical Group Clinic

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

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



Region 8 - West

Suzanne Fletcher-Petrich, CPC, CPC-I, CPC-P

Instructor, Pierce College, Puyallup, Wash.

Suzanne Fletcher-Petrich is a PMCC instructor who networks with students and employers to coordinate internships and jobs. She served on the 2006-2007 AAPC National Advisory Board (NAB), and has been on the AAPCCA board of directors since October 2007. She was president of her chapter in 2007 and 2008, and now serves as new member development officer.

Chapter affiliation: Tacoma, Wash.

Offices held: president, new member development officer



Brenda Edwards, CPC, CPMA, CPC-I, CEMC

Coding and Compliance Specialist, Kansas Medical Mutual Insurance Company

Since Brenda Edwards entered the coding and billing profession 25 years ago, she has been involved in many aspects of coding and billing. Her responsibilities at Kansas Medical Mutual Insurance Company (KaMMCO) include chart auditing, coding and compliance education, and contributing articles to the company website and publication. Edwards is an approved PMCC instructor for AAPC. She is a frequent speaker for local coding chapters in Kansas and Missouri and has presented at AAPC regional conferences. She is co-founder of her chapter.

Chapter affiliation: Topeka, Kan. (Northeast)

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



AAPC Representative

Marti G. Johnson

Director of Local Chapter Support, AAPC

Marti Johnson has seen the number of chapters grow from 30 to more than 440 since she joined AAPC in 1994.

All of her tenure has been dedicated to the establishment and support of AAPC members and local chapters.





www.aapc.com



By Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO

L8680: Don't Allow Confusion to Affect Neurostimulator Coding

Review the facts to ensure appropriate reporting and payer reimbursement.

ode descriptors are supposed to help coders and billers report procedures, services, and supplies more accurately—but that's not always how it works out. Consider medical device code L8680 *Implantable neurostimulator electrode, each,* for example. Over the past two years, the descriptor for this HCPCS Level II code has been a source of confusion. A review of the facts, however, will ensure that you are reporting L8680 accurately, and that payers are reimbursing you appropriately.

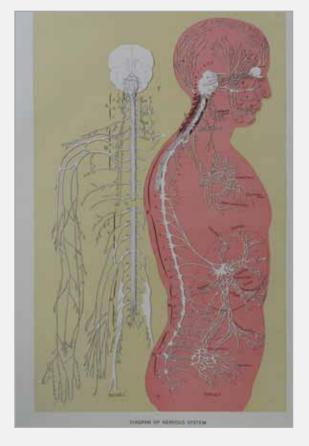
Anatomy of Confusion: A Review of L8680

For 2009 dates of service, the long and short descriptors for HCPCS Level II L8680 specified, "Implantable neurostimulator electrode, each." In November 2009, the Centers for Medicare & Medicaid Services (CMS) released the 2010 Alpha-Numeric HCPCS file, which included a revised long descriptor

"Implantable neurostimulator electrode (with any number of contact points), each." The short descriptor for L8680 was not revised.

The revised long descriptor created confusion due to the ambiguity of the term "electrode." Did CMS intend one unit of L8680 to represent a single electrode? Or, did one unit of service apply to an entire lead, made up of several electrodes? The latter interpretation differed from previous practice, and affected reimbursement dramatically.

To understand why the definition of "electrode" matters so much, you need to review the basics of a neurostimulator device relative to



L8680. Neurostimulators consist of a power source (pulse generator or receiver) to deliver electrical stimulation and one or more electrode array(s) or lead(s). Some systems also use an extension wire as a connection between the lead and power source. The terms "array" and "lead" frequently are used interchangeably.

A neurostimulator array typically contains multiple (usually four to eight) electrodes. From a technical perspective, electrode and contact point are synonymous terms; each electrode equals a single contact point. For example, there are four electrodes or contact points on a single quadripolar array. In 2009, L8680 was coded and billed per electrode—that is, per each contact point. For example, one array with four electrodes (contact points) would be billed L8680 x 4 units of service. The release of the 2010 HCPCS Level II code descriptor revision raised

the question, "Did CMS intend for providers to report the revised HCPCS Level II code with one unit of service (based on the descriptor change `with any number of contact points`)? Or, did CMS intend providers to continue billing L8680 based on the total number of electrodes?"

Members of both physician specialty organizations and medical device manufacturers made multiple inquiries to CMS requesting clarification regarding the revised HCPCS Level II code descriptor and compliant coding.

The publication of 2011 HCPCS Level II, with a correct descriptor for L8680, should have spelled an end to the confusion over how to apply the code.

CMS Restores the 2009 Descriptor

On Dec. 18, 2009, CMS announced that, effective Jan. 1, 2010, it would revert to the 2009 long descriptor for L8680. The code descriptor would remain the same as it was for 2009 dates of service, with one unit of service defined as one electrode or contact point. CMS concurrently released the 2010 HCPCS Level II correction file (www.cms. gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp) that included "Implantable neurostimulator electrode, each" long and short descriptors for L8680.

Unfortunately, the change came too late to be included in the published 2010 HCPCS Level II code books. Because non-Medicare payers may update their HCPCS Level II code files only annually (and, as such, could have implemented the wrong code descriptor for L8680), physician practices had to be diligent in reviewing their 2010 payer explanation of benefits to ensure that L8680 was correctly paid.

2011 May Not End the Confusion

The publication of 2011 HCPCS Level II, with a correct descriptor for L8680, should have spelled an end to the confusion over how to apply the code. Unfortunately, an unspecified number of 2011 HCPCS Lev-

el II codebooks were published with the invalid 2010 descriptor, which included "any number of contact points," instead of the correct code descriptor for L8680, "Implantable neurostimulator electrode, each."

As a result, payers and providers alike may continue to believe, incorrectly, that a single unit of L8680 represents an implantable electrode array with any number of contacts. In fact, correct coding and reimbursement requires a single unit of L8680 for each implanted electrode (contact point). For example, two arrays (leads) with eight electrodes (contact points) each would be coded compliantly as L8680 x 16 units of service ($2 \times 8 = 16$ contact points).

Not only should providers make certain they are billing the medical device implant correctly, they also should review their explanation of benefits for L8680 claims to ensure those claims were processed and paid correctly.

Take Away Tips

Here are some additional points to keep in mind when reporting neurostimulator lead/ electrode medical device implants:

 L8680 is used to report the total number of implanted electrodes (contact points) in a physician office setting.

- L8680 may be used by hospitals and ambulatory surgical centers (ASCs) for reporting outpatient services to non-Medicare payers (be sure to verify individual payer policies/ contracts).
- Outpatient hospitals must use C codes when reporting devices to Medicare. In a hospital outpatient setting, a neurostimulator lead is reported using C1778 Lead, neurostimulator (implantable). This HCPCS Level II code is reported and reimbursed per lead (array), rather than per electrode (contact point).
- Medicare does not allow separate payment for implanted neurostimulator devices in an ASC. Rather, the surgical procedure codes are considered to be deviceintensive procedures and, as such, reimbursement for the implants is included in the payment for the surgical procedure. ■



Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, with MJH Consulting, works in a consulting capacity with manufacturers such as Boston Scientific Corp. to ensure appropriate research and due diligence on coding questions and related assistance.

newly credentialed members

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By Shreka D. Rogers, CPC, CMRS

Stay Balanced

When
Performing the
Coding
vs.
Billing

Dance

With some fancy footwork, you can avoid stepping on the wrong person's toes.

Coding and billing are not the tango. It is, however, a well-choreographed dance that billers and coders must perform to remain compliant while keeping physicians satisfied with their reimbursement. And with tougher federal regulations, reimbursement is becoming increasingly difficult to optimize. Coders are sometimes faced with a critical decision: Do we code correctly, or code to get paid?

The answer is clear: As coders we have a high standard of ethics outlined by AAPC to which we must strive to adhere. The problem is that proper coding isn't black and white in every situation.

For example, a primary care physician requests a neurosurgical consultation for a new patient with three months of cervical radiculopathy (723.0 *Spinal stenosis in cervical region*). The neurosurgeon consults with the patient and forwards a written report back to the referring primary care physician (PCP) with his recommendation for conservative treatment.

In this case, we must be careful to determine correct coding because, depending on the payer, coding may vary. Since 2009, the Centers for Medicare & Medicaid Services (CMS) (including Medicare Advantage) does not recognize CPT° consultation codes 99241-99255; however, some major insurance carriers to date still recognize this series of codes. With that in mind, proper coding would be:

Medicare: 9920x Office or other outpatient visit for the evaluation and management of a new patient ... or 9921x Office or other outpatient visit for the evaluation and management of an established patient ...

Commercial carrier: 9924x Office consultation for a new or established patient ... or 9925x Inpatient consultation for a new or established patient ...

By staying within insurance carrier specified guidelines, you can ensure your physician is reimbursed appropriately while maintaining compliance.

Another example is spinal cord stimulators for ambulatory surgical centers (ASCs). Medicare requires that only 63650 Percutaneous implantation of neurostimulator electrode array, epidural be reported without the device code. Major insurance carriers require 63650 and the device code L8680 Implantable neuro*stimulator electrode, each* to be reported.

L8680 is a Hot Topic

For more information on reporting code L8680, see the article, "L8680: Don't Allow Confusion to Affect Neurostimulator Coding," in this issue of Coding Edge.

Stay Current to Stay Correct

In each of the aforementioned cases, coding matches the guidelines for the insurance carrier being billed. CMS and other major insurance carriers have specific guidelines for billing and coding. That information can be found on CMS' website or the website of the insurance carrier in question. Another benefit for providers are listservs that regularly provide updates and changes for billing and medical policy. By staying within insurance carrier specified guidelines, you can ensure your physician is reimbursed appropriately while maintaining compliance.

Instances when payer policies vary aren't limited to our aforementioned examples, and are almost too numerous to count. So it's important to stay on your toes by regularly reviewing updates and being familiar with insurance carrier payment policies. This will help ensure that you perform with grace the delicate dance of coding vs. billing.



Shreka D. Rogers, CPC, CMRS, has 17+years of health care experience. She is business and coding manager of Howell Allen Clinic and Saint Thomas Outpatient Neurosurgical Center, where she oversees a staff of conscientious coders and accomplished medical records and patient accounting teams. Shreka

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By G. J. Verhovshek, MA, CPC

Use the PFS RVF to Expand Your Coding Knowledge

You'll find a wealth of information in this single spreadsheet.

The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule (PFS) Relative Value File (RVF) is a free, downloadable spreadsheet that compiles loads of useful information—from global periods to supervision requirements to proper modifier application—in a single, easy-to-navigate resource. Taking advantage of this resource can help to make you a better educated and more efficient coder.

Find It First

The PFS RVF is updated regularly on the CMS website (www.cms.gov/PhysicianFeeSched/PFS-RVF/). Files are available going back to 2003, so be sure you refer to the most recent version. The most up-to-date (as of writing this) RVF is named "RVU11B."

After downloading and opening the "RVU11B" folder (compressed in .zip format), you will see over a dozen files in several formats. Of these,

the two most useful are "PPRVU11.

xls" and "RVUPUF11.doc." The first of these files is a Microsoft® Office Excel spreadsheet (saved in .xls format) listing more than 10,000 physician services by CPT® or HCPCS Level II code. This is the RVF. The second file is a Microsoft® Office Word document (.doc) explaining the contents of, and indicators from, the RVF spreadsheet. Together, these two files contain a mother lode of coding information.



The RVF is arranged

alpha-numerically by HCPCS Level II/CPT° code, with the code listed in "column A." You can quickly find any individual code in the spreadsheet by holding down the "Ctrl" (or "command," if you are a Macintosh user) and "F" keys simultaneously, and typing the code you wish to find in the search box.

Several dozen columns follow each code listing, providing a variety of values and indicators. For example, column C contains an abbreviated descriptor of the code, while column F is the first of several columns listing relative value units (RVUs) (work RVUs, practice expense RVUs, facility vs. non-facility totals, etc.).

The accompanying Word document describes the values in each column of the RVF spreadsheet. In other words, it helps you to interpret the RVF. For example, column D of the RVF spreadsheet is labeled "Status Code." The Word file explains that the indicator in this column determines "whether the code is in the fee schedule and whether it is separately payable if the service is covered ... Only RVUs associated with status codes of 'A,' 'R,' or 'T,' are used for Medicare payment." It then explains the meaning of the "A," "R," "T," and other indicators.

Global Guidance Made Easy

Under CMS guidelines, every procedure or service includes a global period, during which payment for the primary procedure or service includes related services and procedures. Global days may be found in column U of the RVF, as defined by one of six indicators:

- 000 Codes with zero-day global periods include related preoperative and postoperative care on the day of the procedure only.
- 010 A 10-day global period includes all related care the day of the procedure and for 10 days following the procedure.
- 090 The 90-day global begins one day prior to the procedure and extends for 90 days.

 These are "major" services, and include



one pre-procedure evaluation (either on the day of or day before the procedure).

- MMM The MMM indicator applies only to maternity codes, to which the usual global period rules do not apply. CPT° guidelines explain, "The services normally provided in uncomplicated maternity cases include antepartum care, delivery and postpartum care."
 - XXX-These services/procedures include only the service or procedure and its "inherent" evaluation and management (E/M) component.
 - YYY CMS has not established a global period for the procedure at a national level. Instead, individual carriers may determine whether the global concept applies.
 - ZZZ The ZZZ indicator is assigned to add-on or bundled codes, which do not have a global period of their own, but are included in another (primary) service's global period.

Knowing the global period of a service/procedure has many applications, not the least of which is deciding whether you may report post-procedure services/procedures separately, and whether modifiers may apply (e.g., modifier 24 *Unrelated evaluation and management service by the same physician during a postoperative period*, modifier 58 *Staged or related procedure or service by the same physician during the postoperative period*, modifier 79 *Unrelated procedure or service by the same physician during the postoperative period*, etc.).

For example, a surgeon performs excisional breast biopsy (19120 Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions) to examine a lump in the patient's left breast. Pathology indicates a malignancy, for which surgeon subsequently performs a modified radical mastectomy (19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but ex-

cluding pectoralis major muscle).

Per chapter one of the National Correct Coding Initiative NCCI Manual for Medicare Policy Services, "If biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable ... if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination." The conditions are met in this example, and we may report both the biopsy (19120) and the mastectomy (19307). But is a modifier required?

Looking at RVF, you see 19120 has a 90-day global period. Because the mastectomy was a more extensive procedure during the global period of a previous procedure, we would append modifier 58 to 19307.

Multiple Procedure Rule Affects Payment

You've probably heard of the "multiple procedure rule," which reduces Medicare payment by 50 percent for the second and subsequent procedures provided to the same patient on the same day. The logic of the rule is that pre- and post-procedure services are "combined" when multiple procedures are performed, which yields efficiencies that should be reflected in reimbursement. Column Y of the RVF determines exactly how the multiple procedure rule affects a given code, per the following indicators:

0 – Multiple procedure reductions do not apply. Usually, the "0" indicator is assigned to add-on codes (and other modifier 51 exempt codes), for which the assigned RVUs account for the "additional" nature of the procedure/ service. Even when submitted with other procedures on the same day, codes with a "0" multiple procedure indicator should be reimbursed at full value.

Spinal bone grafts (e.g., 20930 Allograft, morselized,



Knowing the global period of a service/procedure has many applications, not the least of which is deciding whether you may report post-procedure services/procedures separately, and whether modifiers may apply.

or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)), for example, are "0" indicator codes that always occur with other procedures, such as spinal arthrodesis. Payment for 20930 would be 100 percent of the RVU total, regardless of how many additional procedures were performed during the same session.

- 2 Standard multiple procedure reductions apply. As explained above, payers typically will reimburse 100 percent of the assigned RVUs for the primary procedure and 50 percent of the assigned RVU value for any subsequent procedures. For instance, the physician performs two procedures for which the standard multiple procedure reduction applies. The procedures are valued at 4 RVUs and 2.5 RVUs, respectively. The higher-valued procedure would be paid in full, while payment for the lesser procedure will be reduced by half, for a total of 5.25 RVUs (4 + (2.5/2) = 5.25).
- 3 The "multiple endoscopy" rule applies. Medicare will pay the total RVUs for the highest-valued code in an endoscopic family. Payment for additional, same-day endoscopies in the same family is determined by subtracting the value of the base endoscopy from the value of the additional endoscopy(ies). You can find endoscopic base codes by consulting column AD (Endo Base) of the RVF.

For example, the surgeon performs sigmoidoscopy with tumor removal by hot forceps (45333 Sigmoidscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot forceps or bipolar cautery), followed by polyp removal by snare technique (45338 Sigmoidscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique). Because both scopes are in the same family, Medicare will reimburse the full value of the more extensive procedure (in this case, 45338), and will pay the second scope (45333) minus the value of the base procedure (45330 Sigmoidscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure), as found in column AD). The work value for 45338 is 2.34 RVUs. The work value for 45333 is 1.79 RVUs, from which you must subtract the 0.96 RVUs assigned to the base code, 45330 (which is already paid under the more extensive scope, 45338). The work RVU total for this claim is 3.17 (2.34 + 1.79 – 0.96 = 3.17).

4 – This indicator applies only the technical component of diagnostic imaging procedures, and works in a manner similar to the multiple endoscopy rule. If you report two or more diagnostic imaging tests from the same family (as indicated in column AH, "Diagnostic Imaging Family Indicator"), Medicare will reimburse 100 percent of the technical component value for the first test and 75 percent of the technical component value for each subsequent test. Payment for the professional component is not affected.

9 – The concept of multiple procedures does not apply (Medicare will make no payment adjustment).

Determine Modifier Application at a Glance

Several columns in the RVF pertain to modifier use. For example, column Z (Bilat Surg) indicates whether modifier 50 *Bilateral procedure* properly applies to a code and, if so, how it affects payment. A "0" indicator means that modifier 50 does not apply; a "1" means the payer will pay 150 percent of the fee schedule amount when modifier 50 is applied properly.

For example, 21282 Lateral canthopexy, a unilateral procedure performed on the eye has been assigned a "1" indicator for this column. If the physician performs canthopexy on both eyes, you may append modifier 50. In that case, the RVU total paid to the physician would increase by half.

Whether you may append modifier 62 *Two surgeons* is indicated in column AB (Co-surg). A "0" indicates you may not bill for co-surgeons; a "1" means you may append modifier 62 with documentation to establish medical necessity; a "2" means you may append modifier 62 as long as each of the operating surgeons is of a different specialty, and; a "9" means the concept of co-surgery does not apply (You should not report modifier 62 for these procedures).

For instance, a "1" in the CO-SURG column of 47100 Biopsy of liver, wedge tells you that Medicare will allow payment for two surgeons with modifier 62, as long as documentation can support the need for each surgeon. By the same token, you'd know that reporting 31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure) with modifier 50 would be fruitless because that code is assigned a "0" co-surgery indicator.

Additional columns provide guidance on applying modifiers for team surgery (modifier 66 *Surgical team*) and assistants at surgery (modifiers 80, 81, 82, and AS, depending on the payer and circumstances).

Explore More on Your Own

The highlights above only scratch the surface of what the PFS RVF can reveal. Additional columns provide physician supervision requirements for diagnostic tests, the pre-, post-, and inter-operative values assigned to each code, and separate values for professional (modifier 26 *Professional component*) and technical components (modifier TC *Technical component*) of services. Do yourself a favor: Spend a little time with the RVF (and its explanatory file), and uncover a valuable resource to refine your coding and compliance efforts.

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



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Senate Bill 454:

Time to Rethink Your Participation Status?

The cost of the proposed bill may hit Medicare and Medicaid participants too hard.

For most physicians and health care providers, the decision whether to participate with Medicare and Medicaid has not traditionally required much thought—until now, maybe.

On March 2, Senator Charles Grassley—well known for leading the charge against fraud, waste, and abuse in the Medicare program—proposed S454, the Strengthening Program Integrity and Accountability in Health Care Act of 2011 (SPIAHCA). Eliminating fraud, waste, and abuse in Medicare is a fiscal necessity. S454 is intended to give the secretary of the U.S. Department of Health and Human Services (HHS) more tools to end the days of "pay and chase," and to take a proactive approach toward reducing improper payments under Medicare. This is a desirable goal, but study of the proposal raises the question, "At what cost?"

S454 contains nine sections, each of which gives the secretary of HHS substantial additional authority in the detection and prevention of fraud, waste, and abuse. These include:

- 1. provisions to enhance existing Medicare and Medicaid program integrity provisions
- 2. reporting requirements for the HHS Office of Inspector General (OIG)
- 3. medical identification (ID) theft information sharing
- 4. expanded permissive exclusion provisions
- 5. provisions to make Medicare claims data relative to providers public
- 6. restrictions on Medicaid participation for entities with certain ownership
- 7. control and management affiliations
- 8. restrictions on payments for illegal unapproved drugs
- 9. a requirement for participating individuals or entities with federal health care programs to comply with certain congressional information requests

Among these, the enhanced program integrity and permissive exclusion provisions are potentially the most onerous.

Enhancements to Program Integrity

This section of the act contains two key provisions. The first requires mandatory suspension of Medicare and Medicaid payments pending investigation of "credible allegations of fraud." The current statutory provision gives the secretary discretion to suspend payments in such a circumstance, presumably based on case-specific facts and analysis. The Grassley proposal now makes such a suspension of payment

mandatory. Even in a circumstance where a former employee (for example) makes what the government believes to be a "credible allegation of fraud," payments to that provider or entity must be suspended pending an investigation that could take years.

It is unclear whether this provision would be triggered by the filing of a *qui tam* (whistleblower) case, or whether suspension of payment would occur only if the government decided to intervene. Either way, because these cases are filed under seal, payment could be suspended long before the provider even knows of the allegations or is afforded the opportunity to demonstrate that the allegations lack merit. In the meantime, without the ability to be paid (at least by Medicare/Medicaid), it is more likely that the practice would be forced into bankruptcy before unfounded allegations could be dismissed. As a result, *qui tam* relators would have substantial leverage in forcing providers to settle should this proposal be enacted into law.

The second change under this provision allows for an extension of the time frame in which Medicare claims must be paid. Under this provision, the time frame in which claims must be paid can be extended to 365 days by the HHS secretary in cases where there is merely a "likelihood of fraud, waste, or abuse involving a particular category of providers of services or suppliers, categories of providers of services or suppliers in a certain geographic area, or individual providers of services or suppliers." Although targeting individual providers or suppliers whose billing patterns suggest improper billing might warrant extending the time-period for payment, mere membership in a provider category or being in a particular geographic location does not appear to be a prudent means of enforcement—unless the goal is to drive honest providers out of the system.

If this bill passes, providers who are members of a specialty with a high error rate must consider the possibility of seeing payment delays of up to a year, assuming payment will be forthcoming at all. Because denials of otherwise compensable claims are common for providers on pre-payment review for trivial or perceived documentation errors, the potential of such payment suspensions or delays under this provision of the Grassley proposal does not bode well for continued Medicare participation.

Expansion of Permissive Exclusion Authority

Section five of the Grassley proposal expands the authority of HHS OIG to exclude individuals found to have violated federal health care program requirements in a significant way, and "any individual" who had an ownership interest, or who is an officer or managing employee in a sanctioned entity at the time the conduct responsible



Even in a circumstance where, for example, a former employee makes what the government believes to be a "credible allegation of fraud," payments to that provider or entity must be suspended pending an investigation that could take years.

for conviction or exclusion occurred. In addition to being an owner, officer, or managing employee, the government must also show that the individual knew or "should have known" of the conduct.

Beyond individuals, permissive exclusion can occur to "affiliated entities," who are persons or entities with an ownership or control interest in the sanctioned entity, or who are officers or managing employees in the sanctioned entity at the time of the relevant conduct.

To help put this in context, assume you are the billing manager or vice president of compliance. An issue arises—possibly one that you raise (meaning you knew of the conduct)—and the entity you work for, for whatever reason, is excluded from Medicare as an ultimate result. Based on such a result, because of your position and knowledge of the issue, you also face permissive exclusion as a sanction. A similar result holds for a physician partner in a clinic that gets excluded. Even though the "bad actor" was another physician, if the government can show that any of the other owners knew or "should have known" of the conduct, the physicians not involved in the conduct leading to exclusion can be excluded, as well.

The Grassley proposal significantly strengthens the tools the government has to combat fraud, waste, and abuse. Looking ahead, if fully implemented as written, consider the practical effect on the majority of providers and suppliers who are trying to do things properly. Could they be caught in the dragnet and forced out of participation? If so, who will be left? While eliminating all or most of the providers and suppliers from the system is a surefire way to reduce health care costs, this approach seems analogous to killing the patient to treat the disease.



Miscoe has a bachelor's of science degree from the U.S. Military Academy, a juris doctorate degree from Concord Law School, is the President of Practice Masters, Inc., and the founding partner of Miscoe Health Law, LLC. He is a past member of the AAPC National Advisory Board (NAB) and is a member of the AAPC Legal Advisory Board. He is admitted to the Bar in California and to the practice of law before the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. Miscoe has nearly 20 years experience in health care coding and over

13 years as a compliance expert testifying in civil and criminal cases. He has an extensive national speaking background and has been published in numerous national publications on a variety of coding, compliance and health law topics.

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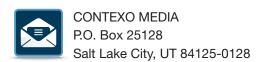
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Get an International Perspective of the Medical World By Ria (Maria) van der Veen, CPC-A

A Dutch citizen provides an inside look into the coder's role in the Netherlands

It's been six years since my husband and I came to the United States from Europe. We had a horse farm in the Netherlands, and we brought the horses with us in hopes of continuing our business. In fact, our imported horse farm did okay the first few years, but I eventually found myself looking for a new career.

I was an educator before owning a horse farm, but I didn't think teaching would be a good option because I had heard teachers were being dismissed all across the country. The health care industry sounded promising, though, so I set my sights on medical coding and billing. Feeling up for the challenge, I signed up for a medical coding and billing course; and in August of last year, I passed the AAPC Certified Professional Coder (CPC*) exam.

Knowing that there may come a day when I have to leave this country, however, I decided knowing how to code in the states wasn't enough. I wanted to know how medical coding and billing is organized in my homeland. What I learned (through much trial and tribulation) is that there is a totally different medical world in the Netherlands and Europe, in general, compared to that in the states.

Disease Classification Coding for Primary Care

I was suprised to learn that, although the universal World Health Organization (WHO) is the cradle of the International Classification of Diseases, Ninth Revision, (ICD-9), this diagnosis coding system is not universally used. In the Netherlands, for example, the International Classification of Primary Care, First Edition (ICPC-1) is the standard for coding and classifying the three elements of the health care encounter: reason for encounter, diagnoses or problems, and process of care.

The ICPC has an internationally established level of chapters and subchapters. The administration is taken care of by the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (Wonca). The Dutch College of General Practitioners (NHG) publishes the Dutch edition of the ICPC-1 and maintains its so-called subsections. Many versions have been published over the years. These days, the Huisarts Informatic Systemen (HIS)—the informatics system for family

doctors—makes use of ICPC-1-2000 or ICPC-1-2002. In November 2009, an updated version of ICPC-1 was published, which contains several new subsections.

The second version of ICPC (ICPC-2) has been in existence since 1998. Very soon ICPC-2 will replace ICPC-1 in the Netherlands. The differences between the two editions are apparent and include considerable changes to certain chapters, sections, and subsections. ICPC-2 has the great advantage of being linked to the International Classification of Diseases, 10th Version (ICD-10), so the medical community will finally see more international connections.

I was disheartended to learn, however, that the automatic search system gives the primary care provider the correct ICPC code during the consultation, so coders are not utilized in family practice.

Disease Classification Coding for Hospitals

Medical coding is completely different for hospitals than it is for primary care. ICD-9 or ICD-10 are used for somatic illness. For psychiatry, hospitals and mental health organizations use the *Diagnostic and Statistical Manual* (DSM), and until recently, medical administrators added the codes on dismissal forms.

Hospital reimbursement, however, is now based on diagnosis treatment combinations (DBCs). This has led to documentation occuring during the care process and performed by the medical specialist, rather than after and performed by the coder. Giving medical specialists the final responsibility for documentation is reportedly causing problems because, many feel, medical specialists are not always correct or careful documenters, and have been known to adapt medical information to match financial information. We certainly aren't allowed to do that here in the states!

The Changing Role of the Coder

Indeed, the hospital coder's role is changing, but perhaps for the better. With the implementation of ICD-10, coders will be expected to participate in the development of laws and regulations, as well as external guidelines, for the administrative organization surrounding the patient.



"... the automatic search system gives the primary care provider the correct ICPC code during the consultation, so coders are not used in family practice."

Some of their tasks will be:

- Administrating definitions and classifications
- Taking samples
- Supplying data to national registration offices

Electronic Health Records (EHRs)

For years, attempts have been made to introduce the Electronic Patient File (EPD) in the Netherlands, but privacy concerns and computer errors have prevented the introduction, so far. Although there is some electronic information exchange on regional levels, the Dutch First Chamber (senate) has re-

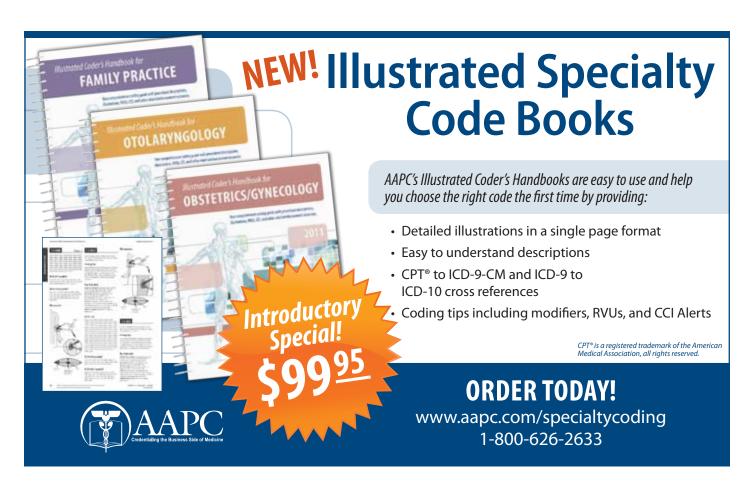
jected the introduction of the EPD and wants to postpone it until current computer glitches are resolved.

It is thought that coders will become more important once EPDs are finally introduced because links will be established between DBCs, international systems, and the medical specialist's own coding system.



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ics, insurance, and medical billing and coding. Ms. van der Veen is an educator and translator who takes her international experience into the medical coding world.



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