Get Ready for Big ICD-9-CM Changes

Kerin Draak, MS, APNP, CPC, CPC-E/M
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On the Cover: Kerin Draak, MS, APNP, CPC, CPC-E/M talks to Brian Dobbins, MD at Prevea Health OB/GYN in Green Bay, Wis. about the extensive array of gynecology codes added to ICD-9-CM for 2009. Cover photo by Mike Roemer of Roemer Photography, Inc. (www.roemerphotography.com).
AAPC Code of Ethics

Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
- Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.
- Members shall respect and adhere to the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

Failure to adhere to these standards, as determined by AAPC, will result in the loss of credentials and membership with the American Academy of Professional Coders.
Impressions to Last a Lifetime

In my travels, I’m afforded the opportunity to see many remarkable places, to meet many noteworthy people, and to witness attention-grabbing situations. When I experience such impressive places, people or moments, I confess, it humbles me. I’m in awe at what others accomplish, sometimes when given so little to work with. Many are things I’ve never done nor could do if I tried. Among these lasting impressions are:

- Tiger Wood’s ability to hit the perfect shot in a clutch. I marvel at how good he is.
- The skyline of New York City. No matter how many times I see it, I’m amazed at how many tall buildings are on a small island.
- How green Pennsylvania is in the summer.
- The sunset from a southern California beach.
- Planning two or three steps ahead. In a decision tree, one event or decision provides an outcome while another event or decision branches out to create a different situation. When someone can plan two or three branches ahead, that grabs my attention. Nothing catches them by surprise.
- Perseverance through difficult problems, not giving up when most would, and finding the strength to achieve what others thought impossible.
- Turning an enemy into a friend.
- A person (or small group) that starts a chapter with five or eight attendees at the first meeting and today the chapter regularly has over 100 attendees.
- A beautifully manicured garden—my thumb is NOT green.
- Writing and publishing a 240 page book on business ethics when you are 80 years old (my neighbor did that).
- How much of a community coders are. A communication goes out saying “I’m giving a presentation tomorrow, does someone have something to help me?” And hours later, voilà! A presentation is offered. I’ve seen it happen so many times.
- Really good sushi and that it tastes better in America than in Tokyo.
- Great foster parents and how selfless they are.
- The speed at which the internet has changed the world (Al Gore aside).
- People who grew up with money and act like everyone else; people who grew up in humble circumstances and act like everyone else.
- 50 year anniversaries.
- Pebble Beach.
- Speaking multiple languages; I’ve tried and failed.
- Surgeons that turn death into life.
- Wisdom—there are a lot of “smart” people, but not as many wise people.

What impresses you? We all have impressive people, places, and things we encounter in our lives—tell me about them. Hit the Talk to Reed button in the Member Tools area at www.aapc.com and let me know what impresses you. I’ll compile a list of your most interesting lasting impressions for a future Coding Edge article. I’m looking forward to reading your impressive experiences.

Sincerely,

Reed E. Pew
CEO and President
As you come across unusual or confounding operative notes, decode them and e-mail copies to us at extreme-coding@aapc.com or by mail to Extreme Coding AAPC, P.O. Box 704004, Salt Lake City, Utah, 84170. We will consider them for inclusion in this regular feature.

**Bulletins Board**

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Help us help your peers by donating redacted procedural notes to the AAPC. The notes will be used for training, for research, and to help build core and specialty exams. Please contact Sheri Bernard at sheri.bernard@AAPC.com

**Tell Us About Novel Ways and Places Where You’ve Earned Your CEUs.**

**Share Ways You’ve Saved Money.** Contact us through letterstotheeditor@aapc.com.
There is global movement going on called “Pay It Forward.” Pay It Forward is a response to the book written by Catherine Ryan Hyde, released in 2000. If you haven’t read the book, there is also a movie based on the book called “Pay It Forward.” I suggest seeing it, as it is one of my favorites. Since the book’s release, many people have joined this movement, including Oprah Winfrey with the Pay It Forward challenge. Pay It Forward was originally a work of fiction that has turned into reality. See the Web site www.payitforwardfoundation.com for details.

The idea of paying it forward is to do something positive for three people, and ask them to pay it back, or Pay It Forward. Three people help three more and so on. The result being, if everyone pays it forward, thousands of people benefit creating a huge movement.

As coders, we should join the movement and Pay It Forward to our members who don’t have continuing education opportunities or who need help with coding issues.

In May, I was asked to donate my time to speak to the Utah Rural Coders at the annual conference in Blanding, Utah. My first reaction was “why would I speak at a conference and not get paid for my time?” After some thought, I decided it would be a good experience and I agreed to donate a couple of days to help Blanding. Blanding and the surrounding area is a very small community with little resources or educational opportunities for coders. They are not given an opportunity to attend AAPC conferences or to attend seminars. Because of limited funding, it is important for people to come to their community to educate them so they can earn CEUs. There are many rural areas across the United States where coders lack this opportunity. I realized we all have an obligation to Pay It Forward—our coders deserve and need this opportunity.

Pay It Forward can be as simple as giving someone coding advice, donating time to ensure a student succeeds, or helping a CPC-A who is struggling to find experience or a good job. If we spend just a few hours a week helping three coders by sharing our knowledge, they’ll pass on the positive work by helping three more coders. The more we share with each other, the stronger our organization becomes. Recently, I discovered something wonderful when I reached out to my colleagues for case studies for a conference at which I was speaking. I wanted good real-life case studies to share with a group of coders. I sent out an S.O.S. for help. I was surprised when many generous colleagues shared their case studies with me to provide help when I desperately needed it. At that moment, I realized many of us Pay It Forward every day without realizing we’re doing it.

Now, it is my turn to Pay It Forward. My goal in the next few weeks is to find three AAPC members to help, and make a difference in their lives. You can do this too. If you, as a member, Pay It Forward, you can enrich your life as well as those you assist.

My challenge to members is to start today with a Pay It Forward attitude. Notice how people respond. Pay It Forward without expecting anything in return and you’ll notice how good you feel after doing something nice for someone you normally wouldn’t help. See how many times each day you can Pay It Forward. Let’s keep the movement alive by reaching out to our coding community and to our members.

Until next month …
The majority of the 2008 changes to the surgery chapter of CPT® can be found in the orthopaedic section. We saw 96 revisions, 24 new codes, and five deleted codes. There are new orthopaedic codes in surgical navigation, spinal osteotomy, elbow tendon repair, femoral fracture repair, treatment of ankle joint, and arthroscopies of the shoulder and subtalar joint.

Most of the revisions are in the “Fracture and/or Dislocation” subsections. In 2008, the words “with or without internal or external fixation” are replaced to say “includes internal fixation, when performed” and the words “external fixation” were removed. If your physician places an external fixation device along with an open treatment of a fracture, CPT® Application of a uniplane (pins or wires in one plane), unilateral, external fixation; or CPT® Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type) would be coded in addition to the open treatment of the fracture code. Note that modifier 51 Multiple procedures has been appended to the codes. For an extensive list of revised codes please refer to Appendix B in your CPT® book.

**Modifier 51 Use**

Other code revisions stemmed from removing the 51 exempt symbols from several grafting (implant) codes. These codes are no longer modifier 51 exempt, meaning they are free to be reported to the primary procedure if modifier 51 Multiple procedures is appended.

- **20660** Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
- **20690** Application of a uniplane (pins or wires in one plane), unilateral, external fixation system
- **20692** Application of a multiplane (pins or wires in more than one plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)
- **20900** Bone graft, any donor area; minor or small (eg, dowel or button)
- **20902** major or large
- **20910** Cartilage graft; costochondral
- **20912** nasal septum
- **20920** Fascia lata graft; by stripper
- **20922** by incision and area exposure, complex or sheet
- **20924** Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)
- **20926** Tissue grafts, other (eg, paratenon, fat, dermis)

Some codes that were previously modifier 51 exempt have been revised and are now considered Add-On codes with the (+) symbol attached to them.
Codes 24357–24359 provide more clarity than 24430–34356.

+20930 Allograft for spine surgery only; morselized (List separately in addition to code for primary procedure)

+20931 structural (List separately in addition to code for primary procedure)

+20936 Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)

+20937 morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

+20938 structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

+22840 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

+22841 Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)

+22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)

+22843 7 to 12 vertebral segments (List separately in addition to code for primary procedure)

+22844 13 or more vertebral segments (List separately in addition to code for primary procedure)

+22845 Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)

+22846 4 to 7 vertebral segments (List separately in addition to code for primary procedure)

+22847 8 or more vertebral segments (List separately in addition to code for primary procedure)

+22848 Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)

+22851 Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)

New and Deleted Codes

+20985 Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)

20986 with image guidance based on intraoperatively obtained images (eg, fluoroscopy, ultrasound) (List separately in addition to code for primary procedure)

20987 with image guidance based on preoperative images (List separately in addition to code for primary procedure)

These three new Add-On codes describe surgical navigation procedures. They are subdivided into whether they are without image guidance; with image guidance based on intraoperatively obtained images; or based on preoperative images.

21073 Manipulation of temporomandibular joint(s) (TMJ) therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)

Remember that there are other codes for manipulation of the TMJ in the 90000s when not using general or monitored anesthesia care. I'd recommend writing a note next to the others if you use this code a lot.

22206 Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic

22207 lumbar

22208 each additional vertebral segment (List separately in addition to code for primary procedure)

These new spinal osteotomy codes describe an osteotomy of three columns. This new osteotomy is used in reconstructive surgery to correct deformities in the sagittal plane, using three columns of bone. This is a different osteotomy than described in CPT® 22210-22214.
Now coders are able to be specific on proximal end femoral fractures

24357  Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer’s elbow); percutaneous
24358  debridement, soft tissue and/or bone, open
24359  debridement, soft tissue and/or bone, open with tendon repair or reattachment

These three codes replace five codes, 24350–24356, and they provide more clarity than the deleted codes.

27267  Closed treatment of femoral fracture, proximal end, head; without manipulation
27268  with manipulation
27269  Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed

There have always been codes for proximal end fracture of the femoral neck (27230-27236) but not for the proximal end of the femoral head. Now coders can be specific on proximal end fractures. Beware that these codes are at the end of the section rather than with the other proximal end codes. It is a good idea to make a note in your CPT® book to “See also codes 27267-27269 for femoral head fractures” by the 27230-27236 codes.

27416  Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft(s))

This code was created to provide physicians a CPT® code for osteochondral autograft(s) done through an open incision rather than arthroscopically. Physicians have had an arthroscopic code for the last few years but now have an open procedure code. Remember if the procedure begins arthroscopically and turns into an open procedure, you would only code the open code, not both. CPT® guidelines state not to report 27415, 29871, 29875, 29884 when performed at the same session and/or 29874, 29877, 29879, 29885-29887 when performed in the same compartment.

27726  Repair of fibula nonunion and/or malunion with internal fixation

We now have one code for the repair of a nonunion fibula with internal fixation. CPT® does not give us choices on the types of repair as it does for the repair of a non union of a tibia (27220-27725).

27767  Closed treatment of posterior malleolus fracture; without manipulation
27768  with manipulation

27769  Open treatment of posterior malleolus fracture, includes internal fixation, when performed

The posterior malleolus is considered one of the three parts of a trimalleolar fracture. We have not had a code for repair of just the posterior malleolus. Remember if your physician repairs the lateral and/or medial malleolus along with the posterior malleolus, you would code a bimalleolar or trimalleolar repair instead.

28446  Open osteochondral autograft, talus (includes obtaining graft(s))

Open osteochondral autograft of talus is a new technology code that foot and ankle surgeons have been waiting for. This procedure takes osteochondral grafts from the non weight-bearing part of the talus or other area and grafts them to the damaged area of the talus.

29828  Arthroscopy, shoulder, surgical; biceps tenodesis

This procedure has been long awaited by orthopaedic surgeons who have performed biceps tendonodesis through the arthroscope for years but the only code they could report was for a procedure done through an open incision. They were forced to report 29999. Unlisted procedure, arthroscopy. We all know what a nightmare it is to use unlisted procedure codes.

29904  Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29905  with synovectomy
29906  with debridement
29907  with subtalar arthrodesis

Foot and ankle surgeons are very happy about having an arthroscopic procedure code for the subtalar joint. The first three codes (29904-29906) are the basic arthroscopic procedure codes with removal of loose foreign body; with synovectomy; with debridement, where 29907 describes subtalar arthrodesis.

2008 brought orthopedic coders a little of everything. There are new technology codes, revised codes (tennis elbow), and new codes for surgeries that have been preformed for years without codes (nonunion of fibula, femoral head, and posterior malleolar fracture, etc.). The variety of revisions are difficult to grasp because the changes are related to each other but are also different from each other (grafting codes no longer being modifier 51 exempt and spine codes that used to be modifier 51 exempt are now Add-On codes).

Don’t forget to talk to your physicians about the changes and update your surgery charge tickets.
TOP 10 Targets of RAC and OIG

10. **Debridement Coding.** Errors in coding surgical debridement vs. active wound care management.
9. **Duplicate Billing.** Filing claims more than once for the same service.
8. **Stark Violations.** Physicians referring patients to services in which they have a financial interest, or in which a family member has a financial interest.
7. **Pharmaceutical Coding in Physician Offices.** Incorrect use of codes or units in billing of injections.
6. **Social Worker Services in Facilities.** Some clinical social worker services provided to inpatients in hospitals or skilled nursing facilities cannot be billed under Part B.
5. **Psychiatric Services.** Overutilization of psychiatric services provided in outpatient settings.
4. **Medical Necessity.** Documentation not supporting the level of service provided to the patient.
3. **E/M Billed During Global Periods.** Use of modifier 24 in billing services that should have been included in the global surgical package.
2. **Place of Service Errors.** Physicians performing services in ASCs or outpatient facilities but billing applying a place of service code indicating the service was performed in the physician office.
1. **Incident-to Errors.** Physician assistants and nurse practitioners performing services for a physician not following billing specific guidelines related to the physician’s relationship to the patient and the physician’s presence in the office.

American Academy of Professional Coders
www.aapc.com
Don’t Impersonate a Fed: Copy Badges Only for Verification

Dear Editor,

In the April Coding Compass article, “Responding to Detected Offenses—Instill Order When Government Investigators Knock at Your Door,” Julie Chicoine stated the importance of verifying investigator’s credentials. While I wholeheartedly agree with this advice, I am curious about her recommendation to "make a copy for future reference" (page 15, paragraph 2 under the heading ‘The Investigators’).

In past experience at numerous conferences, audioconferences, etc. that I and several colleagues have attended on the topic, we have been advised that making a photocopy of the credentials, badge, or other law enforcement official’s identification is not allowed. The information we have indicates a person could potentially be arrested for making the photocopy. We have been advised to obtain the identification, verify the investigator’s identity, and write down the information we are presented with, but never to make a photocopy.

I would like to ask Ms. Chicoine to cite her source for this information to clarify her statement.

Thank you,

Amy L. Tokarz, CPC, CCP
Compliance Specialist

Dear Ms. Tokarz,

I write in response to your question regarding my article. Your question concerns the legality of asking for and making a Xerox copy of an officer’s badge to develop a record keeping system and effective disclosure of health care fraud investigation documents. Specifically, you indicate that the asking to make a copy of an agent’s badge could lead to immediate arrest.

While you cited no authority, I suspect that your question might refer to Title 18, Section 701 of the United States Code, which makes it unlawful to manufacture, (i.e., engrave or photograph, execute), or possess any badge, identification card, or other similar insignia used by the U.S. government’s departments or agencies.

After reading this statute, and consulting a colleague for clarification (a current assistant U.S. attorney with the United States Department of Justice (DOJ), with significant experience in health care fraud investigations), it is my assessment that the statute prohibits making a counterfeit badge. According to my DOJ colleague, asking for and making a copy of a badge for record keeping purposes and establishing basic information at the onset of a health care fraud investigation is not illegal and does not fall within the statute’s preview. My colleague added that “you need to know for sure who you are dealing with” when investigators show up at your door. He added that health care providers will see more situations where multiple agencies representing a whole host of federal and state agencies are involved, posing even greater challenges for health care providers. The only enforcement actions I have found under this statute on the DOJ Web site involve making a false badge and impersonating a federal officer.

In researching your question for purposes of providing you with an answer, I also noted similar guidance regarding photocopies given to library employees in response to warrants under the USA Patriot Act.

Thank you for raising such an interesting question. Even though my research and conversation with a current assistant U.S. attorney leads me to believe that this is one of appropriate options when dealing with federal officials, as discussed in my article, there may be varying agency policies or state specific policies to consider as well. I hope that you or your organization never has to address this issue on a personal basis, but in the unlikely event you do, one option to alleviate your concerns might be to ask the federal agent for permission first and ask for a copy of their policy. Hope this helps.

Julie E. Chicoine, JD, RN, CPC
Integrity Program Compliance Office

Please send your letters to the editor to: lettersstotheeditor@aapc.com.
Private Insurers May Deny Prior C-sections

On average, a Cesarean section (C-section) costs about $2,700 more than a vaginal birth. Because women who give birth via C-section are likely to undergo the procedure again, some insurers may deny individual coverage.

According to the *New York Times*, it is unknown how many women have been denied individual coverage because of a prior C-section. Denials will probably increase as the number of people seeking individual health coverage grows. Births via C-section are at a record-high of 31.1 percent, with more than 1.2 million performed in the U.S. in 2006. Some women who had a C-section can safely deliver vaginally later, but many physicians require C-sections because of the potentially fatal risk of uterine rupture, according to the *New York Times*.

For many payers, previous C-sections aren’t a consideration in coverage decisions, while for other payers it’s a pre-existing condition. Some insurers grant coverage for a C-section only after a certain period of time. Those private insurance companies who do accept women with previous C-sections may charge higher premiums.

Insurers use these tactics for protection, as some customers only apply for coverage after getting sick or pregnant. They may accuse women and obstetricians of conveniently scheduling unnecessary C-sections to avoid labor to avoid covering the expense.

Source: www.nytimes.com/2008/06/01/health/01insure.html?_r=1&oref=slogin

Use G0257 for ESRD EPO and Aranesp Payment

Effective Oct. 1, CMS change request (CR) 6047 revises billing for end stage renal disease (ESRD) related epoetin alfa (EPO) and darbepoetin alfa (aranesp) administrations during unscheduled or emergency dialysis treatment in an outpatient hospital setting. It revises CR 3184, which required the presence of hospital emergency room visit revenue code 045X to allow payment for ESRD-related epoetin alfa (EPO) and darbepoetin alfa (aranesp) provided with an emergency dialysis treatment. Revenue code 045X is no longer required for EPO and aranesp payment for an unscheduled or emergency dialysis treatment.

With the revision, payment of EPO and aranesp is allowed for Healthcare Common Procedure Coding System (HCPCS) Level II codes, Q4081 Injection, epoetin alfa, 100 units (for ESRD on dialysis) and J0882 Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis) only when G0257 Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility is present on the same claim.

In an outpatient hospital setting (13x and 85x bill types), Medicare contractors should only pay for ESRD-related EPO or aranesp when code G0257 appears on the same claim. If G0257 does not appear on the same claim, the outpatient hospital claims should be returned to the provider.

Go to www.cms.hhs.gov/Transmittals/downloads/R1503CP.pdf for the CMS transmittal. For questions, contact your FI or A/B MAC found at www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.
Medicare’s Split/Shared Visit Policy

Rules for Medicare's split/shared visit policy can be a lot to choke down. Here's our simplified interpretation to make it easier to digest.

By Elin Baklid-Kunz, MBA, CPC, CCS
On Oct. 25, 2002, the Center for Medicare & Medicaid Services (CMS) issued Transmittal 1776 giving non-physician practitioners (NPPs) and their supervising physicians increased latitude for hospital and office billing of evaluation and management (E/M) services. The instructions found at www.cms.hhs.gov/transmittals/downloads/R1776B3.pdf allowed NPPs and physicians who work for the same employer/entity to share patient visits on the same day by billing the combined work under the physician’s provider number for 100 percent of the Medicare physician fee schedule (MPFS) reimbursement—although the NPP may have done the majority of the work. Medicare defines NPPs as physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs).

These instructions are referred to as Medicare’s Split/Shared Visit Policy. The policy is one of three billing options for NPPs:

- NPPs own provider number receiving 85 percent of the MPFS amount
- Incident-to the physician receiving 100 percent of the MPFS
- Split/shared service receiving 100 percent of MPFS

Billing using the NPP’s provider number is easy but can cause confusion about Medicare’s Split/Shared Visit Policy when it relates to new patient office or other outpatient visits (CPT® 99201–99205).

Medicare’s Split/Shared Visit Policy
The definition of split/shared visits can be found in the CMS Internet Only Manual (IOM): Medicare Claims Processing Manual Publication 100-04, chapter 12, section 30.6.1.H Split/Shared E/M Visit:

“A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer.”

Different Rules for Different Settings
The split/shared E/M visit policy applies only to selected settings: hospital inpatient, hospital outpatient, hospital observation, emergency department, and office and non-facility clinics. A split/shared E/M visit cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) setting.

When a non-hospital outpatient clinic or physician office E/M visit is split or shared between a physician and a NNP, the E/M encounter may be billed under the physician’s name and provider number if the patient is an established patient and the incident-to rules are met. (Note: Medicare clarifies that incident-to billing is not allowed for new patient visits).

Let’s look at an example. An established patient visits. The NPP performs the history and physical exam and the physician performs the medical decision-making. The “incident-to” requirements are met. In this same example, if the physician and the NPP shared the visit and it does not meet incident-to rules, the entire visit is billed under the NPP’s provider number.

When a hospital inpatient, hospital outpatient, or emergency department E/M visit is split or shared between a physician and a NNP from the same group practice, the E/M visit may be billed under the physician’s name and provider number if the physician provides any face-to-face portion of the E/M encounter (also applies to same day as the NPP’s portion) and the physician personally documents in the patient’s record the physician’s face-to-face portion of the E/M encounter with the patient. (Co-signatures are NOT sufficient).

An example of an E/M visit that may be billed under the physician’s name and provider number is hospital rounds at different times of the day on the same date of service. In a provider-based physician office (i.e., hospital outpatient department) or the emergency room, an example is a new or established patient visit where the NPP performs the history and physical exam, and the physician is the medical decision-maker.

Rule Applies ONLY TO Selected E/M Visits
The split/shared E/M visit rule applies only to selected E/M visits such as these in the hospital settings:
Because incident-to criteria can be applied only in the office and non-facility clinic, the patient must be established.

- hospital admissions (99221-99223)
- follow-up visits (99231-99233)
- discharge management (99238-99239)
- observation care (99217-99220, 99234-99236)
- emergency department visits (99281-99285)
- prolonged care (99354-99357)
- hospital outpatient departments (provider-based visits) (99201-99215)

In a physician office setting, use codes 99211-99215 for an established patient with an established plan of treatment. Incident-to requirements must be met.

**Remember:** Split/shared visits do not apply to consultations (99241-99255), critical care services (99291-99292) or procedures.

**Relationship to Incident-to**

To bill a split/shared visit in the physician office setting, the visit must meet incident-to rules. For the services of a NPP to be covered as incident-to the services of a physician, the services must meet all the requirements for coverage specified in the CMS IOM: Medicare Benefit Policy Manual Publication 100-02, chapter 15 §60-61:

- The service or supplies are an integral, although incidental, part of the physician's or practitioner's professional services
- The services or supplies are of a type that are commonly furnished in a physician's office or clinic
- The services or supplies are furnished under the physician's/practitioner's direct supervision
- The services or supplies are furnished by an individual who qualifies as an employee of the physician, NPP or professional association or group that furnishes the services or supplies
- The service is part of the patient's normal course of treatment, during which a physician personally performs an initial service and remains actively involved in the course of treatment

According to the Medicare Benefit Policy Manual, incident-to apply only to non-institutionalized settings (i.e., not hospital or SNF settings); section 60.1B of the Medicare Claims Processing Manual states:

“For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under 279H§1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary.”

**Can New Patients Office or Other Outpatient Visits (99201–99205) be Split/Shared?**

Because incident-to criteria can be applied only in the office and non-facility clinic, the patient must be established. A hospital outpatient clinic/office is considered a hospital or facility setting, and not a non-institutional setting. Incident-to regulations do not apply and New Patient Office or Other Outpatient Visits (99201–99205) can be reported as a split/shared visit in the hospital outpatient clinic/office (POS 22). The physician must perform some aspect of the E/M service with the patient face-to-face and both the NPP and the physician must personally document what he/she performed.

**Remember:** Exclude the NPP's salary and benefits from the hospital’s cost report when the NPP performs professional services. If the NPP does both facility and professional services, keep time sheets so the expense for professional services can be excluded from the facility’s cost report.

In a provider-based clinic/office, the cost for the hospital staff is reported in the facility’s cost report and reimbursement for the service is received through the facility payment. If the NPP performs professional services, remember to exclude the NPP’s salary and benefits from the cost report. If the NPPs perform both hospital and professional services, keep track of the time spent on professional services so this component can be excluded from the cost report.

The cost report manuals are paper based manuals found at:

[www.cms.hhs.gov/Manuals/PBM/list.asp](http://www.cms.hhs.gov/Manuals/PBM/list.asp)

(publication 15: Provider Reimbursement, Provider Reimbursement Manual Part 1 chapter 21: Cost Related to Patient Care, section 2108: Reimbursement For Services by Provider-Based Physicians)
Provider-based regulations can be found in Transmittal A03-030, CR 2411, April 18, 2003: [www.cms.hhs.gov/transmittals/downloads/A03030.PDF](http://www.cms.hhs.gov/transmittals/downloads/A03030.PDF)

**Documentation of Split/Shared Visits**

Documentation for split/shared visits should follow the documentation guidelines for any E/M Service, and you must follow these documentation requirements:

- Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit.
- The physician’s documentation must clearly indicate that a face-to-face visit took place. (i.e., documenting an exam component to substantiate the physician had a face-to-face visit with the patient, is recommended.)
- Documentation must support the combined service level reported on the claim.
- Auxiliary staff may document the review of systems, past family history, and social history. The physician and NPP must personally review this documentation and confirm and/or supplement it in the medical record.

If the physician does not personally perform and document a face-to-face portion of the E/M encounter with the patient, then the E/M encounter is not billed under the physician’s name and provider number and is billed only under the NPP’s name and provider number.

If the physician’s participation is only reviewing the patient’s medical record, the service is billed under the NPP’s name and provider number. Payment will be made at the appropriate physician fee schedule based on the provider number entered on the claim.

**Acceptable Physician Documentation**

Because teaching physician services involving residents is somewhat analogous to split/shared visits, these examples from the CMS material on teaching physician services (CMS Pub.100-4, Chapter 12, Section 100.1.1.A General Documentation Instruction and Common Scenarios), help establish acceptable documentation for split/shared visits:

- “I performed a history and physical examination of the patient and discussed his management with the NPP. I reviewed the NPP note and agree with the documented findings and plan of care.”

The physician must perform some aspect of the E/M service with the patient face-to-face and both the NPP and the physician must personally document what he/she performed.

- “I saw and evaluated the patient. I reviewed the NPP’s note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.”
- “I saw and evaluated the patient. Agree with NPP’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

Examples of unacceptable documentation by a physician:

- “Agree with above,” followed by legible countersignature or identity.
- “Rounded, Reviewed, Agree,” followed by legible countersignature or identity.
- “Discussed with NPP. Agree,” followed by legible countersignature or identity.
- “Seen and agree,” followed by legible countersignature or identity.
- “Patient seen and evaluated,” followed by legible countersignature or identity.
- A legible countersignature or identity alone.

Such documentation is not acceptable as it is not possible to determine whether the physician was present, evaluated the patient, and/or had any involvement with the plan of care.

**Scribing Is Not a Billable Service**

A scribe’s role is to document in the medical record a physician’s visit with the patient. In a hospital setting, a scribe makes rounds with the physician and documents the visit. Scribing is not a billable service and is not always straightforward. For example, it is no longer considered scribing if the NPP adds an opinion to the progress note.

If your hospital or office uses scribes, establish a protocol that clearly outlines scribes to not render any opinions and to provide an accurate transcription of physicians’ comments. Watch out for scribes who improve documentation to facilitate optimization of the claim to maximize revenue.

Guidelines for scribes published by First Coast Service Option, the Part B carrier for Florida and Connecticut in the third quarter 2006 Part B update ([www.floridamedicare.com/Part_B/Medicare_B_Update/Archive/106399.pdf](http://www.floridamedicare.com/Part_B/Medicare_B_Update/Archive/106399.pdf)) are:
If a nurse or NPP acts as a scribe for the physician, the individual writing the note, history, discharge summary, or any entry in the record, should note “written by X, acting as scribe for Dr. Y.” Dr. Y should co-sign, indicating the note accurately reflects work and decisions made.

It is inappropriate for an employee of the physician to make rounds and write entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.

Scribes should record entries upon dictation by the physician, and should clearly document the level of service provided at that encounter. This requirement is no different from other encounter documentation requirements.

Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to deliver services and create the record. There is no carrier Part B incident-to billing in the hospital setting (inpatient or outpatient). The scribe should only write what the physician dictates and does, acting independently there is no payment for this activity.

Understand Private Payer Differences

There is a distinction between Medicare regulations and private payers’ policies. Medicare rules do not necessarily impact private payers. Some payers may defer to state law, so understand your state’s scope of practice. Follow the requirements set out by private payers. Some hospitals query private payers to see what their rules are. An alternative to querying the private payers is to send the private plans a certified letter advising the hospital’s procedures plan for billing NPP service, unless the plan advises the hospital otherwise, in writing. When querying payers about policies, ask how to report services such as critical care and consultations.

Most private payers do not issue numbers to NPPs and request that billing occur under a supervising physician. Some payers may only ask to follow state law when NPPs deliver care. For such cases, it might be appropriate for the NPP to provide care without a physician face-to-face encounter in the emergency room and bill the private payer under the physician’s number.

Follow Medicaid’s State Rules

Medicaid also has different rules from Medicare when it comes to NPPs. Check your local state Medicaid Web site for your state’s rules. Medicaid pays NPPs on a separate fee schedule and has a separate limitation and coverage book for NPPs.

In Florida, NPP services under the direct supervision of a physician may be billed using the physician’s provider number instead of the NPPs provider number with some exceptions. Florida Medicaid direct supervision means the physician is on the premises when the services are rendered and he/she reviews, signs, and dates the medical record.

Get on Target with Split/Share Visits Compliance

In January’s incident-to article, Robert Pelaia Esq., CPC identified incident-to billing as completely transparent to the payer. This transparency exists for split/shared visit billing as well. When a claim for a split/shared visit is received for reimbursement, it looks just like a claim for a physician service and the provider usually gets paid for the claim even if it did not comply with the split/shared visit policy. Although transparent to the payer, non-compliance with the split/shared visit policy could be an easy target for Recovery Audit Contractors (RACs) when the permanent RAC program starts. In the revised scope of work released on Nov. 7, 2007, E/M codes were added to the services list that RAC can review. The RAC will also have hospital and provider specific medical record request limits and they may only send the provider one review result per claim. This may lead to auditors checking for multiple issues before sending denial letters. Because the RACs have the complete medical record and the claims submitted, it will be very easy to identify a progress note documented by the NPP and merely signed by the physician.

With the permanent RAC program near, now is a good time to a review a few internal progress notes for compliance with the split/shared visit policy. You may discover your physicians are not aware of the face-to-face requirement for billing split/shared visits, do not realize incident-to rules do not apply in emergency room and provider-based offices, or are using the split/shared visits for consultations.

Elin Baklid-Kunz, MBA, CPC, CCS, works for Halifax Health in Daytona Beach, Florida. Kunz has 15 years of health care experience, including seven years in finance. She is a freelance writer for HCPro, Inc. JustCoding.com, and presents workshops for the AAPC. She is an adjunct professor at Seminole Community College. Kunz earned her master’s degree in business administration from Stetson University and her bachelor’s degree from Florida International University.
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<th>2008 Course Schedule</th>
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<td>Seattle, WA; Little Rock, AR; Asheville, NC</td>
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In June, more than 1,800 coders and other medical professionals came together to celebrate medical coding and teach and learn coding excellence at the 16th National Coding Conference in Orlando, Fla.

Hot topics, such as “Medicare’s Incident-to Rules,” presented by Hugh Aaron, MHA, JD, CPC, CPC-H, and the AAPC Legal Advisory Committee’s “Legal Trends and Issues,” hashed out a lot of pressing questions many coders have with constantly changing coding rules and regulations. All sessions were informative, but space limits us to focus on one. After all, we may enjoy the exhibitors, freebies, SeaWorld, the resort atmosphere, and CEUs that attending a national conference brings, but the bottom line of what we are seeking is coding knowledge.

High-risk pregnancies are complicated as they require more time and more clinic resources. Many times payers’ software does not allow proper adjudication, and contracting is sometimes inadequate. Although CPT® defines global care for uncomplicated pregnancy, it does not specifically address the issue for high-risk pregnancy. For the obstetrical global package, CPT® describes all services provided in a non-complicated case—including antepartum care, delivery, and postpartum care. Carriers do not always follow CPT® or American College of Obstetricians and Gynecologists (ACOG) guidelines. Always check with your payers to verify what services are covered and included, and what benefits are afforded to the patient.

High-risk indications include medical conditions with the mother, risk factors or potential risks, abnormality of the fetus, hospitalizations occurring outside the admission for delivery, and a need for consultation or intervention by physicians with additional training. **Note:** Not every problem or issue renders a pregnancy high-risk.

**Component Coding**

If the admitting primary care physician does not perform the delivery due to complications requiring a Caesarian-section (C-section), the admitting physician may report:

- Prenatal visits (as appropriate)
- Initial hospital admit
- Prolonged attendance when medically necessary
- Assistant at C-section (on delivery only, code 59514-80 Cesarean delivery only; Assistant Surgeon)
- Hospital discharge
- Postpartum care (as appropriate)

**Concurrent/Co-management Care**

For concurrent/co-management care, the general obstetrician (OB) seeing the patient for regular visits should document on the prenatal flow sheet and document in the notes who is co-managing the patient and for what medical reason. Specialists seeing the patient periodically for monitoring, ultrasound, lab, and other reasons should separately document services; not on the antenatal flow sheet. These services are outside of the global package.

**Prenatal Testing**

To measure the movement of the fetus and heart rate and to monitor uterine contractions code 59025 Fetal non-stress test for non-stress testing (NST) services.

To code the amniotic fluid index (AFI), use 76815 Ultrasound, pregnant uterus, real-time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses to measure fluid.
Use codes 76818 Fetal biophysical profile; with non-stress testing and 76819 Fetal biophysical profile; without non-stress testing for biophysical profile (BPP) (physiologic test) of baby’s heart rate, muscle tone, movement, and breathing. Remember to add results of NST.

**Ultrasound Billing**

Ultrasounds do not include pre- and post-op elements and stand alone. Counseling, consultation and discussions with the patient are services in addition to the ultrasound. Modifier 51 isn’t appropriate as these services should not be discounted. Use of modifier 59 as directed in CPT® will eliminate the reduction while telling the payer the services were for separate fetuses.

For multiple gestations, code appropriately using CPT® codes: 76801, 76802; 76805, 76810; 76813, 76814; 76818, 76818-59; 76819, 76819-59; 76820, 76820-59; and 76821, 76821-59. Use documentation requirements as per the American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal-Fetal Medicine (SMFM), and the American Institute of Ultrasound in Medicine (AIUM) guidelines.

**E/M Visits and Consultations**

Consultations must meet request, render, and report requirements and establish the course of treatment for the patient. Evaluation and management (E/M) visits can be for new or established patients. E/M visits can be billed by time (> 50 percent counseling); however, they cannot be billed as such “I spent 40 minutes with patient of which > 50 percent of the time was spent counseling the patient about ….” Counseling, education, answering questions, etc., are billable E/M services. A modifier is not required with an ultrasound, unless the payer tells you to get this in writing. Payers may toggle between allowed diagnosis codes; check with carriers for correct code usage.

**ICD-9-CM Coding**

Chapter 11 codes take priority over codes from other chapters. It is the physician’s responsibility to state the reported condition is not complicating the pregnancy (per ICD-9-CM coding guidelines). Codes from other chapters can be used in conjunction to specify a condition. Make sure to read all ICD-9-CM notes given.

**642 Hypertension**

Hypertension complicates a pregnancy. Is the hypertension pre-existing, what manifestations are present, and are they superimposed to other problems? Does the patient have edema or an abnormal lab result? Hypertension in a pregnant patient may:

- require anti-hypertensives,
- result in additional prenatal visits to monitor maternal blood pressure (BP),
- require antenatal testing to verify well-being of the fetus (NST, BPP, fetal echo),
- provoke testing for decreased fetal movement, oligohydramnios, and pre-eclampsia,
- and put additional stress on the placenta.

Use ICD-9-CM codes 642.0X–642.9X for hypertension. When referring to this series of ICD-9-CM codes you may need clarification on these medical terms:

- Pre-eclampsia is borderline hypertension, albuminuria, and unresponsive edema between 20 weeks gestation and first week post partum. With pre-eclampsia there is an excess weight gain of two plus pounds in one week and may have excessive swelling of hands, feet, and face. BP of pre-eclampsia is greater than 140/90. Look for albuminuria and elevated creatinine on 24-hour urine. The timing of delivery is critical.

- Eclampsia is very much the same as pre-eclampsia/toxemia but can be accompanied by convulsions, coma, and edema.

- HELLP syndrome is severe pre-eclampsia with severe hypertension, hemolytic anemia, elevated liver function tests, and low platelet count. The treatment is delivery.

**644 Early Labor**

Turn to ICD-9-CM’s 644 series for labor between the gestational age of 22-37 weeks, and turn to 640 series for labor prior to gestational age of 22 weeks. Codes 644.0X Early or threatened labor; threatened premature labor, premature labor after 22 weeks, but before 37 completed weeks of gestation and 644.1X Early or threatened labor; other threatened labor specify without delivery. Code 644.21 Early or threatened labor; Early onset of delivery is used for delivery before 37 weeks. Result of early delivery could be hospitalization requiring hydration, tocolysis, bed rest, monitoring of contractions, and home monitoring.

**646 Other Complications NEC**

Many complications or illnesses are spelled out in the ICD-9-CM 646 code series as not elsewhere classified (NEC). Use the appropriate code; use additional codes to further specify complication.

**Example:** If a patient has pyelonephritis in pregnancy, code 646.63 Other complications of pregnancy, not elsewhere classified; Infections of genitourinary tract in pregnancy; antepartum condition or complication and 590.1X Infections of kidney; Acute pyelonephritis.

If you attended the national conference and missed sessions you wish you had attended, you can download the presentations online at www.aapc.com/conferences/orlando-national-conference.aspx.
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Bravo to Cynthia Norling, CCS-P, CPC-H. She was inducted into Cambridge Who’s Who (www.cambridgewhoswho.com) for information management excellence on May 25. She is a coding educator and research coordinator for PrimeWest Health and shows information management dedication, leadership, and excellence. Norling has 28 years of professional experience and is a coding educator and research coordinator who specializes in teaching medical coding. She conducts webinars, workshops, and onsite presentations, and coordinates research programs on coding for all departments. She attributes her success to hard work, dedication, willingness to learn, and readiness to adapt to coding changes.

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Not only are there a record number of ICD-9-CM diagnostic code changes for 2009, but the changes affect virtually every specialty. We have dozens of new codes for diabetes, scores for headaches, codes to report family and personal problems that result from military deployment, codes for leukemias in relapse, and several new fever codes. There are new codes for decubitus ulcers, for Pap test results of vulvar and anal tissue, and codes for benign and malignant carcinoid tumors. There are also new codes for eosinophilic disease, methicillin-resistant Staphylococcus aureus (MRSA), and codes for a variety of pox infections. The breadth of the new codes is too wide to adequately address in Coding Edge, but a full list of new codes and index revisions can be found on page 25-27.

All services beginning Oct. 1 must be coded using the new ICD-9-CM codes. Make sure your office has a handle on the changes now to ensure implementation is systematic and complete. Here’s a checklist of what you need to do.

Determine where the buck stops. Someone in your office should be responsible for ensuring complete and accurate transition to the new codes. It’s important, painstaking work, and if no one has traditionally assumed this role, volunteer to take charge. The scope of implementation crosses several departments, but having a centralized dissemination of information and coordination of codes makes the change easier for everyone.

Define the territory. Put pen to paper and identify every electronic or paper document in your office with embedded codes. Create a checklist and timeline for updating all coded documents.

Educate yourself. Spend a few hours reviewing the changes to the tabular and index sections of ICD-9-CM. Use a highlighter to mark charges that will affect your practice. Keep in mind that some new codes, like the 249 category for secondary diabetes, will likely be used across every specialty.

Educate the clinicians. Oftentimes, new codes require adjustments in documentation. Don’t expect your physicians to take the same level of interest in code changes you do. Instead, create for each physician a “cheat sheet” of impacts based on the new codes. Identify the new codes affecting them with the documentation by each code. For example, documentation regarding Staphylococcus aureus will now be identified as methicillin susceptible or methicillin resistant for proper coding.

Educate the coders. The entire staff of coders and billers should discuss in detail the changes and how they will affect day-to-day coding and billing. The changes to “includes” and “excludes” notes and the index should also be discussed, as these can affect code selection. Outside training in the form of audio seminars or workshops are useful for all, or at least for leaders who bring the information back to the team. Education is the key to successful application of new codes.

Talk to the IT team. Bring your information technology folks up-to-date on the changes as early as possible. IT is a key player during code update season.

Order books or software updates. It’s important to have up-to-date resources for your team to perform successfully. Some think they can get away with buying new books every other year, but the revenue lost to miscoded claims is much more than the cost of updated resources. It’s never a mistake to invest in current code books.

Archive a set of old books. Keep a history of year-to-year changes somewhere in your office, as well as a set of old books. Code histories can come in handy as educational tools showing the origins of codes, for correct mapping of codes for practice pattern analysis, and for denials or legal issues that span the years.

Sheri Poe Bernard, CPC, CPC-H, CPC-P, is vice president of member relations at the American Academy of Professional Coders (AAPC).
# New 2009 ICD-9-CM Codes

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<td>Malignant carcinoid tumor of the duodenum</td>
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<tr>
<td>209.02</td>
<td>Malignant carcinoid tumor of the jejunum</td>
</tr>
<tr>
<td>209.03</td>
<td>Malignant carcinoid tumor of the ileum</td>
</tr>
<tr>
<td>209.10</td>
<td>Malignant carcinoid tumor of the large intestine, unspecified portion</td>
</tr>
<tr>
<td>209.11</td>
<td>Malignant carcinoid tumor of the appendix</td>
</tr>
<tr>
<td>209.12</td>
<td>Malignant carcinoid tumor of the cecum</td>
</tr>
<tr>
<td>209.13</td>
<td>Malignant carcinoid tumor of the ascending colon</td>
</tr>
<tr>
<td>209.14</td>
<td>Malignant carcinoid tumor of the transverse colon</td>
</tr>
<tr>
<td>209.15</td>
<td>Malignant carcinoid tumor of the descending colon</td>
</tr>
<tr>
<td>209.16</td>
<td>Malignant carcinoid tumor of the sigmoid colon</td>
</tr>
<tr>
<td>209.17</td>
<td>Malignant carcinoid tumor of the rectum</td>
</tr>
<tr>
<td>209.20</td>
<td>Malignant carcinoid tumor of unknown primary site</td>
</tr>
<tr>
<td>209.21</td>
<td>Malignant carcinoid tumor of the bronchus and lung</td>
</tr>
<tr>
<td>209.22</td>
<td>Malignant carcinoid tumor of the thymus</td>
</tr>
<tr>
<td>209.23</td>
<td>Malignant carcinoid tumor of the stomach</td>
</tr>
<tr>
<td>209.24</td>
<td>Malignant carcinoid tumor of the kidney</td>
</tr>
<tr>
<td>209.25</td>
<td>Malignant carcinoid tumor of foregut, NOS</td>
</tr>
<tr>
<td>209.26</td>
<td>Malignant carcinoid tumor of midgut, NOS</td>
</tr>
<tr>
<td>209.27</td>
<td>Malignant carcinoid tumor of hindgut, NOS</td>
</tr>
<tr>
<td>209.29</td>
<td>Malignant carcinoid tumor of other sites</td>
</tr>
<tr>
<td>209.30</td>
<td>Malignant poorly differentiated neuroendocrine carcinoma, any site</td>
</tr>
<tr>
<td>209.40</td>
<td>Benign carcinoid tumor of the small intestine, unspecified portion</td>
</tr>
<tr>
<td>209.41</td>
<td>Benign carcinoid tumor of the duodenum</td>
</tr>
<tr>
<td>209.42</td>
<td>Benign carcinoid tumor of the jejunum</td>
</tr>
<tr>
<td>209.43</td>
<td>Benign carcinoid tumor of the ileum</td>
</tr>
<tr>
<td>209.50</td>
<td>Benign carcinoid tumor of the large intestine, unspecified portion</td>
</tr>
<tr>
<td>209.51</td>
<td>Benign carcinoid tumor of the appendix</td>
</tr>
<tr>
<td>209.52</td>
<td>Benign carcinoid tumor of the cecum</td>
</tr>
<tr>
<td>209.53</td>
<td>Benign carcinoid tumor of the ascending colon</td>
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<tr>
<td>209.54</td>
<td>Benign carcinoid tumor of the transverse colon</td>
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<tr>
<td>209.55</td>
<td>Benign carcinoid tumor of the descending colon</td>
</tr>
<tr>
<td>209.56</td>
<td>Benign carcinoid tumor of the sigmoid colon</td>
</tr>
<tr>
<td>209.57</td>
<td>Benign carcinoid tumor of the rectum</td>
</tr>
<tr>
<td>209.60</td>
<td>Benign carcinoid tumor of unknown primary site</td>
</tr>
<tr>
<td>209.61</td>
<td>Benign carcinoid tumor of the bronchus and lung</td>
</tr>
<tr>
<td>209.62</td>
<td>Benign carcinoid tumor of the thymus</td>
</tr>
<tr>
<td>209.63</td>
<td>Benign carcinoid tumor of the stomach</td>
</tr>
<tr>
<td>209.64</td>
<td>Benign carcinoid tumor of the kidney</td>
</tr>
<tr>
<td>209.65</td>
<td>Benign carcinoid tumor of foregut, NOS</td>
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<tr>
<td>209.66</td>
<td>Benign carcinoid tumor of midgut, NOS</td>
</tr>
<tr>
<td>209.67</td>
<td>Benign carcinoid tumor of hindgut, NOS</td>
</tr>
<tr>
<td>209.69</td>
<td>Benign carcinoid tumor of other sites</td>
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<td>238.77</td>
<td>Post-transplant lymphoproliferative disorder (PTLD)</td>
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<tr>
<td>249.00</td>
<td>Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified</td>
</tr>
<tr>
<td>249.01</td>
<td>Secondary diabetes mellitus without mention of complication, uncontrolled</td>
</tr>
<tr>
<td>249.10</td>
<td>Secondary diabetes mellitus with ketoacidosis, not stated as uncontrolled, or unspecified</td>
</tr>
<tr>
<td>249.11</td>
<td>Secondary diabetes mellitus with ketoacidosis, uncontrolled</td>
</tr>
<tr>
<td>249.20</td>
<td>Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified</td>
</tr>
<tr>
<td>249.21</td>
<td>Secondary diabetes mellitus with hyperosmolarity, uncontrolled</td>
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<tr>
<td>249.30</td>
<td>Secondary diabetes mellitus with other coma, not stated as uncontrolled, or unspecified</td>
</tr>
<tr>
<td>249.31</td>
<td>Secondary diabetes mellitus with other coma, uncontrolled</td>
</tr>
<tr>
<td>249.40</td>
<td>Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified</td>
</tr>
<tr>
<td>249.41</td>
<td>Secondary diabetes mellitus with renal manifestations, uncontrolled</td>
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<td>249.50</td>
<td>Secondary diabetes mellitus with ophthalmic manifestations, not stated as uncontrolled, or unspecified</td>
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<td>249.51</td>
<td>Secondary diabetes mellitus with ophthalmic manifestations, uncontrolled</td>
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<tr>
<td>249.60</td>
<td>Secondary diabetes mellitus with neurological manifestations, not stated as uncontrolled, or unspecified</td>
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<tr>
<td>249.61</td>
<td>Secondary diabetes mellitus with neurological manifestations, uncontrolled</td>
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<tr>
<td>249.70</td>
<td>Secondary diabetes mellitus with peripheral circulatory disorders, not stated as uncontrolled, or unspecified</td>
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<td>249.71</td>
<td>Secondary diabetes mellitus with peripheral circulatory disorders, uncontrolled</td>
</tr>
<tr>
<td>249.80</td>
<td>Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified</td>
</tr>
<tr>
<td>249.81</td>
<td>Secondary diabetes mellitus with other specified manifestations, uncontrolled</td>
</tr>
<tr>
<td>249.90</td>
<td>Secondary diabetes mellitus with unspecified complication, not stated as uncontrolled, or unspecified</td>
</tr>
<tr>
<td>249.91</td>
<td>Secondary diabetes mellitus with unspecified complication, uncontrolled</td>
</tr>
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<td>259.50</td>
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</tr>
<tr>
<td>259.51</td>
<td>Androgen insensitivity syndrome</td>
</tr>
<tr>
<td>259.52</td>
<td>Partial androgen insensitivity</td>
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<tr>
<td>275.5</td>
<td>Hungry bone syndrome</td>
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<tr>
<td>279.50</td>
<td>Graft-versus-host disease, unspecified</td>
</tr>
<tr>
<td>279.51</td>
<td>Acute graft-versus-host disease</td>
</tr>
<tr>
<td>279.52</td>
<td>Chronic graft-versus-host disease</td>
</tr>
<tr>
<td>279.53</td>
<td>Acute on chronic graft-versus-host disease</td>
</tr>
<tr>
<td>288.84</td>
<td>Heparin-induced thrombocytopenia (HIT)</td>
</tr>
<tr>
<td>337.00</td>
<td>Idiopathic peripheral autonomic neuropathy, unspecified</td>
</tr>
<tr>
<td>337.01</td>
<td>Carotid sinus syndrome</td>
</tr>
<tr>
<td>337.09</td>
<td>Other idiopathic peripheral autonomic neuropathy</td>
</tr>
<tr>
<td>339.00</td>
<td>Cluster headache syndrome, unspecified</td>
</tr>
<tr>
<td>339.01</td>
<td>Episodic cluster headache</td>
</tr>
<tr>
<td>339.02</td>
<td>Chronic cluster headache</td>
</tr>
<tr>
<td>339.03</td>
<td>Episodic paroxysmal hemicrania</td>
</tr>
<tr>
<td>339.04</td>
<td>Chronic paroxysmal hemicrania</td>
</tr>
<tr>
<td>339.05</td>
<td>Short lasting unilateral neuralgiform headache with conjunctival injection and tearing</td>
</tr>
<tr>
<td>339.09</td>
<td>Other trigeminal autonomic cephalgia</td>
</tr>
<tr>
<td>339.10</td>
<td>Tension type headache, unspecified</td>
</tr>
</tbody>
</table>
Make sure your office has a handle on the changes now to ensure implementation is systematic and complete.

339.11 Episodic tension type headache
339.12 Chronic tension type headache
339.20 Post-traumatic headache, unspecified
339.21 Acute post-traumatic headache
339.22 Chronic post-traumatic headache
339.3 Drug induced headache, not elsewhere classified
339.41 Hemicrania continua
339.42 New daily persistent headache
339.43 Primary thunderclap headache
339.44 Other complicated headache syndrome
339.81 Hypnic headache
339.82 Headache associated with sexual activity
339.83 Primary cough headache
339.85 Primary stabbing headache
339.89 Other headache syndromes
346.02 Migraine with aura, without mention of intractable migraine with status migrainosus
346.03 Migraine with aura, with intractable migraine, so stated, with status migrainosus
346.12 Migraine without aura, without mention of intractable migraine with status migrainosus
346.13 Migraine without aura, with intractable migraine, so stated, with status migrainosus
346.22 Variants of migraine, not elsewhere classified, without mention of intractable migraine with status migrainosus
346.23 Variants of migraine, not elsewhere classified, with intractable migraine, so stated, with status migrainosus
346.30 Hemiplegic migraine, without mention of intractable migraine with status migrainosus
346.31 Hemiplegic migraine, with intractable migraine, so stated, without mention of status migrainosus
346.32 Hemiplegic migraine, without mention of intractable migraine with status migrainosus
346.33 Hemiplegic migraine, with intractable migraine, so stated, with status migrainosus
346.40 Menstrual migraine, without mention of intractable migraine with status migrainosus
346.41 Menstrual migraine, with intractable migraine, so stated, without mention of status migrainosus
346.42 Menstrual migraine, without mention of intractable migraine with status migrainosus
346.43 Menstrual migraine, with intractable migraine, so stated, with status migrainosus
346.50 Persistent migraine aura without cerebral infarction, without mention of intractable migraine with status migrainosus
346.51 Persistent migraine aura without cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus
346.52 Persistent migraine aura without cerebral infarction, without mention of intractable migraine with status migrainosus
346.53 Persistent migraine aura without cerebral infarction, with intractable migraine, so stated, with status migrainosus
346.60 Persistent migraine aura with cerebral infarction, without mention of intractable migraine with status migrainosus
346.61 Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, without mention of status migrainosus
346.62 Persistent migraine aura with cerebral infarction, without mention of intractable migraine with status migrainosus
346.63 Persistent migraine aura with cerebral infarction, with intractable migraine, so stated, with status migrainosus
346.70 Chronic migraine without aura, without mention of intractable migraine with status migrainosus
346.71 Chronic migraine without aura, with intractable migraine, so stated, without mention of status migrainosus
346.72 Chronic migraine without aura, without mention of intractable migraine with status migrainosus
346.73 Chronic migraine without aura, with intractable migraine, so stated, with status migrainosus
346.82 Other forms of migraine, without mention of intractable migraine with status migrainosus
346.83 Other forms of migraine, with intractable migraine, so stated, with status migrainosus
346.92 Unspecified migraine, without mention of intractable migraine with status migrainosus
346.93 Unspecified migraine, with intractable migraine, so stated, with status migrainosus
362.20 Retinopathy of prematurity, unspecified
362.22 Retinopathy of prematurity, stage 0
362.23 Retinopathy of prematurity, stage 1
362.24 Retinopathy of prematurity, stage 2
362.25 Retinopathy of prematurity, stage 3
362.26 Retinopathy of prematurity, stage 4
362.27 Retinopathy of prematurity, stage 5
364.82 Plateau iris syndrome
372.34 Pingueculitis
414.3 Coronary atherosclerosis due to lipid rich plaque
511.81 Malignant pleural effusion
511.89 Other specified forms of effusion, except tuberculous
530.13 Eosinophilic esophagitis
535.70 Eosinophilic gastritis without mention of hemorrhage
535.71 Eosinophilic gastritis with hemorrhage
558.41 Eosinophilic gastroenteritis
558.42 Eosinophilic colitis
569.44 Dysplasia of anus
571.42 Autoimmune hepatitis
599.70 Hematuria, unspecified
599.71 Gross hematuria
599.72 Microscopic hematuria
611.81 Ptosis of breast
611.82 Hypoplasia of breast
611.83 Capsular contracture of breast implant
611.89 Other specified disorders of breast
612.0 Deformity of reconstructed breast
612.1 Disproportion of reconstructed breast
625.70 Vulvodynia, unspecified
625.71 Vulvar vestibulitis
625.79 Other vulvodynia
649.70 Cervical shortening, unspecified as to episode of care or not applicable
649.71 Cervical shortening, delivered, with or without mention of antepartum condition
649.73 Cervical shortening, antepartum condition or complication
678.00 Fetal hematologic conditions, unspecified as to episode of care or not applicable
678.01 Fetal hematologic conditions, delivered, with or without mention of antepartum condition
678.03 Fetal hematologic conditions, antepartum condition or complication
678.10 Fetal conjoined twins, unspecified as to episode of care or not applicable
678.11 Fetal conjoined twins, delivered, with or without mention of antepartum condition
678.13 Fetal conjoined twins, antepartum condition or complication
679.00 Maternal complications from in utero procedure, unspecified as to episode of care or not applicable
679.01 Maternal complications from in utero procedure, delivered, with or without mention of antepartum condition
679.02 Maternal complications from in utero procedure, delivered, with mention of postpartum complication
679.03 Maternal complications from in utero procedure, antepartum condition or complication
679.04 Maternal complications from in utero procedure, postpartum condition or complication
679.10 Fetal complications from in utero procedures, unspecified as to episode of care or not applicable
679.11 Fetal complications from in utero procedures, delivered, with or without mention of antepartum condition
679.12 Fetal complications from in utero procedures, delivered, with mention of postpartum complication
679.13 Fetal complications from in utero procedures, antepartum condition or complication
679.14 Fetal complications from in utero procedures, postpartum condition or complication
689.10 Erythema multiforme, unspecified
695.10 Stevens-Johnson syndrome
695.11 Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome
695.12 Erythema multiforme major
695.13 Exfoliation due to erythematous condition
695.14 Exfoliation due to erythematous condition involving less than 10 percent of body surface
695.15 Exfoliation due to erythematous condition involving 10-19 percent of body surface
695.16 Exfoliation due to erythematous condition involving 20-29 percent of body surface
695.17 Exfoliation due to erythematous condition involving 30-39 percent of body surface
695.18 Exfoliation due to erythematous condition involving 40-49 percent of body surface
695.19 Exfoliation due to erythematous condition involving 50-59 percent of body surface
695.56 Exfoliation due to erythematous condition involving 60-69 percent of body surface
695.57 Exfoliation due to erythematous condition involving 70-79 percent of body surface
695.58 Exfoliation due to erythematous condition involving 80-89 percent of body surface
695.59 Exfoliation due to erythematous condition involving 90 percent or more of body surface
707.20 Pressure ulcer, unspecified stage
707.21 Pressure ulcer, stage I
707.22 Pressure ulcer, stage II
707.23 Pressure ulcer, stage III
707.24 Pressure ulcer, stage IV
707.25 Pressure ulcer, unstable stage
729.90 Disorders of soft tissue, unspecified
729.91 Post-traumatic seroma
729.92 Nontraumatic hematoma of soft tissue
729.99 Other disorders of soft tissue
760.61 Newborn affected by amniocentesis
760.62 Newborn affected by other in utero procedure
760.63 Newborn affected by other surgical operations on mother during pregnancy
760.64 Newborn affected by previous surgical procedure on mother not associated with pregnancy
777.50 Necrotizing enterocolitis in newborn, unspecified
777.51 Stage I necrotizing enterocolitis in newborn
777.52 Stage II necrotizing enterocolitis in newborn
777.53 Stage III necrotizing enterocolitis in newborn
780.60 Fever, unspecified
780.61 Fever presenting with conditions classified elsewhere
780.62 Postprocedural fever
780.63 Postvaccination fever
780.64 Chills (without fever)
780.65 Hypothermia not associated with low environmental temperature
780.72 Functional quadriplegia
788.91 Functional urinary incontinence
788.99 Other symptoms involving urinary system
795.07 Satisfactory cervical smear but lacking transformation zone
795.10 Abnormal glandular Papanicolaou smear of vagina
795.11 Papanicolaou smear of vagina with atypical squamous cells of undetermined significance (ASC-US)
795.12 Papanicolaou smear of vagina with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
795.13 Papanicolaou smear of vagina with low grade squamous intraepithelial lesion (LSIL)
795.14 Papanicolaou smear of vagina with high grade squamous intraepithelial lesion (HSIL)
795.15 Vaginal high risk human papillomavirus (HPV) DNA test positive
795.16 Papanicolaou smear of vagina with cytologic evidence of malignancy
795.18 Unsatisfactory vaginal cytology smear
795.19 Other abnormal Papanicolaou smear of vagina and vaginal HPV
796.70 Abnormal glandular Papanicolaou smear of anus
796.71 Papanicolaou smear of anus with atypical squamous cells of undetermined significance (ASC-US)
796.72 Papanicolaou smear of anus with atypical squamous cells cannot exclude high grade squamous intraepithelial lesion (ASC-H)
796.73 Papanicolaou smear of anus with low grade squamous intraepithelial lesion (LSIL)
796.74 Papanicolaou smear of anus with high grade squamous intraepithelial lesion (HSIL)
796.75 Anogenital high risk human papillomavirus (HPV) DNA test positive
796.76 Papanicolaou smear of anus with cytologic evidence of malignancy
796.77 Satisfactory anal smear but lacking transformation zone
796.78 Unsatisfactory anal cytology smear
796.79 Other abnormal Papanicolaou smear of anus and anogenital HPV
997.31 Ventilator associated pneumonia
997.39 Other respiratory complications
998.30 Disruption of wound, unspecified
998.33 Disruption of traumatic wound repair
999.81 Extravasation of vesicant chemotherapy
999.82 Extravasation of other vesicant agent
999.88 Other infusion reaction
999.89 Other transfusion reaction
V02.53 Methicillin susceptible Staphylococcus aureus MSSA colonization
V02.54 Methicillin resistant Staphylococcus aureus MRSA colonization
V07.51 Prophylactic use of selective estrogen receptor modulators (SERMs)
V07.52 Prophylactic use of aromatase inhibitors
V07.59 Prophylactic use of other agents affecting estrogen receptors and estrogen levels
V12.04 Methicillin resistant Staphylococcus aureus V13.51 Personal history of pathologic fracture
V13.52 Personal history of stress fracture
V13.59 Personal history of other musculoskeletal disorders
V15.21 Personal history of undergoing in utero procedure during pregnancy
V15.22 Personal history of undergoing in utero procedure while a fetus
V15.29 Personal history of surgery to other organs
V15.51 Personal history of traumatic fracture
V15.59 Personal history of other injury
V23.85 Pregnancy resulting from assisted reproductive technology
V23.86 Pregnancy with history of in utero procedure during previous pregnancy
V28.81 Encounter for fetal anatomic survey
V28.82 Encounter for screening for risk of pre-term labor
V28.89 Other specified antenatal screening
V45.11 Renal dialysis status
V45.12 Noncompliance with renal dialysis
V45.87 Transplanted organ removal status
V45.88 Status post administration of IPA (rIPA) in a different facility within the last 24 hours prior to admission to current facility
V46.3 Wheelchair dependence
V51.0 Encounter for breast reconstruction following mastectomy
V51.8 Other aftercare involving the use of plastic surgery
V61.01 Family disruption due to family member on military deployment
V61.02 Family disruption due to return of family member from military deployment
V61.03 Family disruption due to divorce or legal separation
V61.04 Family disruption due to parent-child estrangement
V61.05 Family disruption due to child in welfare custody
V61.06 Family disruption due to child in foster care or in care of non-parental family member
V61.09 Other family disruption
V62.21 Personal current military deployment status
V62.22 Personal history of return from military deployment
V62.29 Other occupational circumstances or maladjustment
V87.01 Contact with and (suspected) exposure to arsenic
V87.09 Contact with and (suspected) exposure to other hazardous metals
V87.11 Contact with and (suspected) exposure to aromatic amines
V87.12 Contact with and (suspected) exposure to benzene
V87.19 Contact with and (suspected) exposure to other hazardous aromatic compounds
V87.2 Contact with and (suspected) exposure to other potentially hazardous chemicals
V87.3 Contact with and (suspected) exposure to other potentially hazardous substances
V87.31 Contact with and (suspected) exposure to mold
V87.39 Contact with and (suspected) exposure to other potentially hazardous substances
V87.41 Personal history of antineoplastic chemotherapy
V87.42 Personal history of monoclonal drug therapy
V87.49 Personal history of other drug therapy
V88.01 Acquired absence of both cervix and uterus
V88.02 Acquired absence of uterus with remaining cervical stump
V88.03 Acquired absence of cervix with remaining uterus
V89.01 Suspected problem with amniotic cavity and membrane not found
V89.02 Suspected placental problem not found
V89.03 Suspected fetal anomaly not found
V89.04 Suspected problem with fetal growth not found
V89.05 Suspected cervical shortening not found
V89.09 Other suspected maternal and fetal condition not found
E927.0 Overexertion from sudden strenuous movement
E927.1 Overexertion from prolonged static position
E927.2 Excessive physical exertion from prolonged activity
E927.3 Cumulative trauma from repetitive motion
E927.4 Cumulative trauma from repetitive impact
E927.8 Other overexertion and strenuous and repetitive movements or loads
E927.9 Unspecified overexertion and strenuous and repetitive movements or loads
Transthoracic echocardiography is an important tool used to assess the structure and function of the heart. Although the test is non-invasive and introduces virtually no risk to the patient, it provides a wealth of information that frequently alters the course of patient management. Echocardiography is one of the largest sources of profit for most cardiology groups. Due to the frequency of echocardiography testing, and its influence on the bottom line, it is essential to accurately code and document it. Failure to take proactive steps toward correct coding could expose your practice to detrimental liability.

Most echocardiographic studies include three separate tests: two-dimensional (2-D) echocardiography, Doppler interrogation, and color flow study. Each of these tests is separately reported and each generates separate reimbursement.

Use 93307 and 93308 to Reflect 2-D Echocardiography

Ultrasound used to non-invasively visualize the size and movement of heart structures is 2-D echocardiography. A transducer sends millions of sound waves into the patient’s body, at several different angles, every second. Sound waves travel into the chest, bounce off of various cardiac structures, and then travel back to the transducer. Because the sound waves are sent in specific sequences, it is possible to monitor the round trip of each sound wave. Sound waves reflect differently off various tissues in the body. Based on the way sound waves reflect off anatomic structures, and the “round trip,” duration, the computer can generate a 2-D image of the structure: the heart chambers, the cardiac valves, the aortic root, and the pericardium.

When coding for the 2-D portion of the transthoracic echocardiographic study, there are two codes to choose from. The first option, code 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete, is commonly referred to as a “complete-echo.” The second option, code 93308 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study, is commonly referred to as a “limited echo.”

Financially, the difference between the payment rates for complete and limited echocardiograms is considerable. Medicare and most other payers compensate nearly twice as much for a complete echocardiographic study as they do for a limited echocardiographic study. Prior to 2005, the distinction between complete and limited echocardiographic studies was defined by a small portion of payers. Guidelines in the 2005 CPT® established a nationwide distinction between these two services. The introductory section to echocardiographic codes states a full echocardiographic study is one that includes “2-dimensional and selected M-mode examination of the left and right atria, left and right ventricles, the aortic, mitral, and tricuspid valves, the pericardium, and adjacent portions of the aorta.” For each of these areas “appropriate measurements are obtained and recorded.”

The documentation standard established in CPT® is very similar to the “report text” documentation requirements established by Intersocietal Commission for the Accreditation of Echocardiography Laborato-
icael documentation requirements establish that the interpretative report portion of the echo report must contain each element listed in the cpt® standard plus the 2-d assessment of the pulmonic valve.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>ICAEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left Atrium</td>
<td>X</td>
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<tr>
<td>Right Atrium</td>
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<tr>
<td>Left Ventricle</td>
<td>X</td>
</tr>
<tr>
<td>Right Ventricle</td>
<td>X</td>
</tr>
<tr>
<td>Aortic Valve</td>
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<tr>
<td>Mitral Valve</td>
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<td>Tricuspid Valve</td>
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<tr>
<td>Pericardium</td>
<td>X</td>
</tr>
<tr>
<td>Adjacent Portions of Aorta</td>
<td>X</td>
</tr>
<tr>
<td>Pulmonic Valve</td>
<td>X</td>
</tr>
</tbody>
</table>

Due to the frequency of echocardiography testing and its influence on the bottom line, it is essential to accurately code and document it.

For most echocardiographic studies, if any of the nine anatomic structures required by CPT® is not specifically documented as being evaluated in the final echocardiographic report, the service should be coded as a limited study (93308), rather than a complete study (93307). CPT® recognizes it may not be possible to assess each of these structures despite significant effort. For example, sometimes a good acoustic window can't be obtained because of the shape, structure, or size of the patient's body. In such circumstances, the report should explain why the missing information could not be obtained. As established in CPT®, if the report reflects technical difficulties precluding the doctor from assessing each of the above structures, code 93307 is appropriate.

When the doctor performs a follow-up study of the heart at a later date, report code 93308. These follow-up studies usually focus on a specific area of the heart, rather than on the entire heart.

**Code Doppler Imaging the Right Way**

Doppler imaging is based on an observation made by Christian Johann Doppler in 1842. The concept of the Doppler effect is easily explained with the analogy of waves in the ocean rather than with sound waves. Waves rolling into shore from the ocean move at a fairly constant rate. If a ship moves from the shore out to sea, waves would hit the front of the ship at a certain rate. If the ship was to move from the ocean toward the shore, the waves would make contact with the ship at a much slower rate: in the first example the ship is meeting each wave at the half-way point, in the second example the wave and the ship are moving in the same direction.

In the echo lab, the principal of the Doppler effect applies to sound waves sent into the patient’s body, and then we assess how frequently and forcefully ultrasonic sound waves reflect off individual red blood cells. By measuring variations in the
reflected sound waves, clinicians can determine the speed and direction of blood cells in the heart. Doppler studies assess valvular performance. The cardiac valves should open to facilitate blood flow in the proper direction, and then slam shut to prevent regurgitation (blood flow in the wrong direction). If valves are damaged or calcified, a substantial amount of blood could flow in the wrong direction. By assessing the velocity and direction of blood flow on each side of the cardiac valves, clinicians can assess how much blood is flowing in the wrong direction. This is frequently referenced as quantifying valvular regurgitation. Doppler data allows doctors to estimate blood pressure inside the heart and the cardiac output. CPT® contains two codes to report Doppler studies. Similar to echo codes, the Doppler codes are referred to as complete or limited studies. They are:

**93320** Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete

**93321** Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study

Unlike the 2-D echocardiography, CPT® does not establish the difference between complete and limited Doppler studies. To gain insight regarding this, look at the ICAEL, documentation standard. It establishes, “A complete Doppler study is one that examines every cardiac valve, and the atrial and ventricular septa for antegrade and/or retrograde flow. In addition, a complete Doppler study provides functional hemodynamic data.” While this standard is not officially incorporated into CPT® instruction, it is probably a safe guideline to follow as there is a high degree of overlap and concurrence between the CPT® and ICAEL definitions of complete vs. limited 2-D echocardiographic studies.

**Go with 93325 for Color Flow**

In this assessment, the computer uses data obtained from Doppler waves to label blood cells a certain color based on their travelling direction. Most systems label blood cells moving toward the transducer as red and those moving away from the transducer as blue. By color coding blood cells based on the direction they travel, we can identify the presence and severity of valvular regurgitation illustrated by a contrasting jet of blood flowing in the wrong direction across a valve (a regurgitant jet). Color flow studies also allow clinicians to identify septal defects, areas of stenosis, and the presence of shunts.

A color flow study is a visual assessment of blood flowing through the heart. Unlike 2-D and Doppler studies, the color flow study does not produce numeric measurements. While the ICAEL standard references that “any regurgitation, shown in at least two imaging planes with color Doppler” should be documented, there are no reliable guidelines as to definitive documentation in the report to support the performance and interpretation of the color flow study. It is best to specifically document when a color flow study is performed and provides a brief summary of what is revealed: normal or abnormal.

Unlike the 2-D echocardiography and Doppler studies, there is only one code to report a color flow study: 93325 Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiographic imaging). There is no distinction between complete and limited color flow studies.

**Check the Add-on Status**

Because the Doppler and color flow codes are listed as add-on codes in CPT®, the + symbol is listed next to these codes. CPT® notes to only report these add-on codes when certain base codes are reported. These restrictions are:

**+93320**—use in addition to 93303, 93304, 93307, 93308, 93312, 93314, 93315, 93317, or 93350.

**+93321**—use with the same list as 93320.

**+93325**—use in addition to the same list, plus 76825, 76826, 76827, 76828, (fetal echo codes) or 93320, 93321.
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I work hard informing my staff and clients of the constant changes to health care coding and billing regulations. To keep up with the Office of Inspector General’s (OIG) compliance plan, my employees maintain an ongoing log of communication between our clients, insurance carriers, and themselves.

Record keeping helps us pinpoint weak areas in both offices and allows us to find practice management solutions. For many, keeping proof of facsimile transmissions, email, traditional mail, and telephone conversations may seem paranoid. I see it as protection for employees and clients, should they wrongfully be accused of suspicious behavior. Incident and corrective action reports are kept in a client's file to ensure communication delivery and follow through.

If reported incidents are ignored by a client after numerous citations, we give final warning and ultimately terminate our relationship for non-compliance. This may sound harsh, but we do everything we can to help our clients and trust they want to follow the rules as much as we do. Some physicians are too busy and others trust their office manager to handle their problems; either way, negligence places both offices in a precarious position.

Although I am apprehensive when it comes to liability issues, I do my best to help anyone before we part ways. Sometimes, when you try to do right and help clients, trouble can still arise. For 28 years, my employees and I had not come in contact with a dishonest health care professional. Some were questionable, but we never uncovered proof of unlawful activity.

Knock, Knock, Knock
I thought we had our clients’ practices under control until two government security agents representing Health and Human Services (HHS) and OIG barged into my office holding up badges and asked if I was Jo-Anne Sheehan, owner of Lomar Associates.

I felt my knees weaken as I answered and my mind went through a checklist of things that might have gone wrong.

- Did I owe the IRS money and fail to send them a check?
- Was someone in my office suspicious of illegal behavior?
- Did I not shred patient information properly?

I was at a loss. I am the person who will not walk across a lawn if the sign reads “Do Not Walk on the Grass.” What could I have done to warrant such a frightening encounter? These agents were professional and behaved sternly. I immediately recognized the seriousness of their visit.

The female agent rambled off my Social Security number, home address, and other personal information, asking for verification. I answered her questions and wondered how she knew so much about me.

“Do you provide billing services for a Janice Smith (name changed), owner of Physical Therapy, Inc. (name changed)?”

I responded with “Yes” and added that I terminated my business relationship with her for non-compliance of corrective action citations. We were, however, continuing to bill services for her as a courtesy while she looked for a new company to take over, I explained.

“We are here because we believe that Janice Smith is in serious trouble with Medicare. She is currently under criminal investigation,” the male agent said.

My heart sank; I thought this may happen one day. I wondered if Janice and her office manager were naive or intentionally ignoring the problems cited within the practice. My staff questioned her ethics but I wanted to believe Janice was a nice woman who didn’t understand the seriousness of her billing and coding practices. I was wrong.

The final question the female agent asked said it
all to me. “Did you write an anonymous letter to Medicare stating that Janice Smith was guilty of Medicare fraud?”

My Answer Was “No!”

A series of visits took place involving intense staff questioning from agents. Phone calls flowed between the government, my office, and my attorney. Medical records were confiscated. No conversation took place between Janice and my staff during the initial investigation.

I’ll never recover the time lost assisting the agents, but what I learned was invaluable—the government believes you are innocent until proven guilty and wants to work with providers to help them understand correct service documentation.

Some audits reveal inaccuracy and cost practices’ money, particularly if services were overcharged based on a provider’s documentation, but this is classified as abuse and not deliberate.

All it takes is one anonymous letter to Medicare citing reasons why a medical provider might be guilty of fraud and abuse and investigations begin. It is commonplace to monitor practices for unbundling/bundling and over/under charging, and to have medical records requested for review of questionable practices; however, when someone blows the whistle on a health care professional citing evidence, the investigation is of a different nature.

No Stone is Left Unturned

Now, I understand why the OIG promotes paper trails of communication through incident and corrective action reports. This proof of dialogue helps clients and third parties during a criminal investigation. I shudder to think of what my business may have endured or been accused of if I had not followed this component of the OIG’s compliance plan. The documented warnings I sent to Physical Therapy, Inc. were available for the agents.

If a provider is tried before a grand jury and sent to jail for fraud, they are convicted felons. The government doesn’t have time to bring every abuser to trial, so if a physician or ancillary provider reaches this level of the investigation, they are in serious trouble. My former client, a new mom, is serving ten months in federal prison for fraud and will be on two years probation after her jail term. I do not believe she is an evil person; however, greed got the better of her and she didn’t think she would get caught.

Learn, Maintain, and Teach Coding Excellence

Most providers run their practices ethically while maximizing reimbursement to compensate for continuing reductions. It is our expertise as certified coders to capture all billable services for providers. We serve our clients and teach them coding techniques that are appropriate to help steer clear of compliance interrogations.

As long as the medical profession requires legal documentation to back up their services, certified coders are in demand. Coding is a profession we have worked hard to attain, and our love of coding which prompts us to maintain CEUs, test our coding knowledge, attend chapter meetings and seminars, and spread the word about the importance of coding excellence.

To report fraud you can call the OIG Hotline at 800-HHS-TIPS.

Fax: 800-223-8164
E-mail: HHSTips@oig.hhs.gov
TTY: 800-377-4950
Mail: Office of the Inspector General
Dept of Health & Human Services
Attn: Hotline
PO Box 23489
Washington, DC 20026

The government believes you are innocent until proven guilty and wants to work with providers to help them understand correct service documentation.
HOW TO DISSECT OPERATIVE REPORTS & FIND MISSING PIECES
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Learn the best approach to coding operative reports. This seminar provides you with specific techniques to abstract necessary information from complex documentation. Discover coding tools that deliver the best value, and tips to help physicians improve documentation for optimal transference to correct codes. In this comprehensive and hands-on seminar, you will learn an easy 10-step process for physician coding using real, redacted operative reports that represent the most complex coding scenarios. This process applies to all surgical specialties and provides you with:

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- Report unlisted procedures and get paid for them.
- Best practices for avoiding unbundling mistakes.
- Proper use of modifier 51 and 59 and the specialties most affected.
- Create outcomes that are correct, productive and painless.

Why you should attend: You should attend if you are a coder, biller, in the allied healthcare industry, or any part of your job involves responsibility for the physician coding or billing of surgical procedures.

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Joseph Kipling, an English author and poet, is credited with once saying that words are the most powerful drug used by mankind. Nowhere is this statement’s truth more clear than in physician/patient communication. Frequently, coders wear many hats in the medical setting and often have contact with both physicians and patients. Similarly, coders observe physician and patient interaction and may field patient complaints about the physician or their practice. To help reduce liability and increase patient satisfaction, there are things that can be done to improve communication between physician and patient.

Recently I had the pleasure of meeting with Alan Williams, JD., the author of the best-selling medical malpractice prevention book “Physician, Protect Thyself: 7 Simple Ways NOT to Get Sued for Medical Malpractice.” Mr. Williams has defended physicians, health care providers, hospitals, medical schools, and health care facilities throughout his entire legal career.

Mr. Williams presents convincing evidence in his book showing effective communication in the medical setting is powerful. When questioned about the most important challenges facing physicians today, one third of responding physicians cited medical malpractice insurance and/or claims, according to a study published in the New England Journal of Medicine. Although the thought of malpractice lingers in the minds of physicians and health care providers, studies show subsequent to an adverse medical incident, physicians and health care providers are the ones who have the most control over whether a malpractice claim is filed.

A study published in the American Journal of Medicine concluded physicians who were rated in the bottom third of patient satisfaction surveys had a 110 percent increased risk of having a malpractice claim filed against them as compared to physicians rated in the top third. Another study published in the Journal of the American Medical Association (JAMA) found that physicians without a malpractice claim filed against them more often: laughed and used humor, asked patients their opinions, encouraged patients to talk and interact, educated patients regarding expectations, and spent an average of over three minutes longer per visit with patients, than physicians who previously had multiple malpractice claims filed against them.

A Harvard study reported less than three percent of hospitalized patients with injuries or death directly attributable to medical negligence filed malpractice claims, showing that another factor besides medical quality determines whether a patient files a malpractice claim. Researchers at Harvard, MIT, and the
University of Michigan conclude: when physicians and health care providers don't adequately communicate with their patients after a complication or adverse medical incident, patients often file malpractice claims to determine if any medical negligence occurred. This suggests that physicians’ and health care providers’ communication and interaction with patients is a determining factor of a malpractice claim, even in cases where the physician or health care provider rendered substandard care.

During our conversation, Mr. Williams suggested ways for physicians to improve patient satisfaction and reduce the chance of being sued for medical malpractice. The main recommendations were:

- **Sit down:** Patients believe a physician or health care provider who sits during a portion of the visit has spent more time with them than a provider who stand throughout the visit, although the time spent was exactly the same.

- **Listen to your patient:** On average, physicians and health care providers interrupt a patient just 17 seconds into their complaint description, according to a study published in JAMA. Interrupting a patient so soon communicates that the physician is not interested in hearing what the patient is saying.

- **Face the patient:** Providers should rotate their bodies to fully engage the patient when speaking with them. Studies indicate when physicians or health care providers face more than 45 degrees away from a patient the patient has a negative impression of the visit.

- **Look at the patient:** Research reveals that when speaking to a patient, they must look at you 80 percent of the time and you must look at them 90 percent of the time to fully comprehend what you say. Other studies show only one in six American adults understand rudimentary medical discussions such as a “negative” test result is good, a “malignancy” means cancerous, etc.

- **Review the chart before entering the room:** When two people meet for the first time, each judges the other within the first ten seconds and that judgment is usually permanent—don’t let the patient’s first impression be of the top of the provider’s head as they frantically skim the chart walking into the room.

- **The Physical Examination (PE):** From the patient’s perspective, the PE is the most awkward and embarrassing aspect of receiving medical care. Providers must do all they can to ensure privacy and dignity when performing an examination. A negative and degrading patient experience may convince the patient to file a malpractice claim after an adverse medical incident.

There may be opportunities to incorporate some of these recommendations into your professional career and your patient interactions. Mr. Williams’s tips don’t cost any money to implement and the return on investment is increased patient satisfaction and reductions in potential liability claims. Speak the same language as your patients and help the physicians you work with do the same.

Alan Williams, JD. is president of Physicians Medical Legal Prevention, LLC. To contact him please e-mail Alan@PhysiciansMedicalLegalPrevention.com.

Studies show subsequent to an adverse medical incident, physicians and health care providers are the ones who have the most control of whether a malpractice claim is filed.
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Faced With a Reconstructive Nightmare

Sometimes when you are coding, the devil is in the details. Such is the case of the patient requiring reconstruction post-adenocystic carcinoma with craniofacial excision. The cancer was in the patient’s salivary glands and surrounding areas, and reconstruction required a bone graft with skull base, maxillary, nasal, orbital and palatal reconstruction using split-thickness calvarial bone graft, fat graft, and myocutaneous free flap. Alloderm was also used as a graft material.

The patient’s malignancy has been removed, leaving significant disfigurement. The primary diagnosis for this patient is V51 Aftercare involving the use of plastic surgery. Because the patient is still undergoing treatment (radiotherapy), a secondary diagnosis of personal history of cancer would be premature. Instead, the secondary diagnosis should be 195.0 Malignant neoplasm of head, face and neck, since the cancer was not limited to the salivary glands.

The number of structures involved in this procedure make the CPT® coding difficult, and may lead coders to 21299 Unlisted craniofacial and maxillofacial procedure. Provide documentation to underscore the complex nature of the procedure. Supplying a list of codes that most closely parallel the procedures performed may assist the payer in establishing fees for the procedures. The content of the operative note requires query of the physician, as this procedure is divided among a neurosurgeon, an ENT, and the dictating physician, and it is unclear in some cases who performed which portions of the reconstruction.
Indications: A 45-year-old woman presented with a primary complaint of lower abdomen pain, reporting a regular abdominal growth and healthy fetal activity from a pregnancy that happened 18 years earlier. She had not pursued prenatal follow-up. In the third trimester, she started to feel strong cramps in the lower abdomen at the same time that fetal activity disappeared. She didn't look for medical assistance and some weeks later she eliminated a dark red mass through the vagina with a placental appearance. She experienced the characteristic modifications of breast lactation. The abdomen had started to decrease but retained an infra-umbilical mass of about 20 centimeters in diameter, mobile and painless. A few months before being seen by us, she started to feel the described pain.

Procedure: An abdominal X-ray and computerized tomography showed the presence of an ectopic fetus in a mesentery blood vessel branch with peripheral calcifications. The ultrasound examinations showed an empty uterus, regular ovaries, and the presence of a 31-week fetus (determined from femur length).

We suspected lithopedion, and because of the symptoms and the patient’s desire to remove the mass, we performed an exploratory laparotomy. After performing parietal celiotomy, an oval tumor was seen with adherence of the right ovary and epiploon. It measured 15 x 25 centimeters and weighed 1,890 grams. It was composed of a calcified ovular membrane adhering to a fetus, which was dissected and proved to be well conserved and partially calcified.

The tumor was removed and the wound closed with layered sutures.
Smoking and Alcohol Addiction: Tough Codes to Crack!
Be Ready as More Patients Seek Help
By Meera Mohanakrishnan, MSc, CPC

There are two codes for tobacco use cessation counseling and two codes for alcohol and/or substance abuse screening and brief intervention for providers to use. These codes differ from evaluation and management (E/M) services that should be reported separately for patients with a behavior considered an illness, such as tobacco use, substance abuse, or obesity. The four CPT® codes are as follows:

- **99406** Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- **99407** greater than 10 minutes
- **99408** Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
- **99409** greater than 30 minutes

**Kick Bad Coding Habits**

Tobacco use is the leading cause of preventable disease and death in the United States. Smoking affects nearly every organ of the body. Tobacco dependence is a chronic condition that often requires repeat intervention. The benefits are greater for those who quit at an early age; however, smoking cessation is beneficial at any age.

Smoking cessation counseling consists of a physician providing patients with information to help them stop smoking. Smoking cessation counseling includes the following steps:

- **Step 1:** Asking the smoker about smoking status and history.
- **Step 2:** Counseling the smoker to help him or her to stop smoking.
- **Step 3:** Assessing the smoker’s willingness to set a quit date.
- **Step 4:** Assisting the smoker using a written plan. If appropriate, the “assisting” step may also include prescribing smoking cessation pharmacotherapy, as needed.
- **Step 5:** Tracking the progress of the smoker’s attempt to stop smoking.

**Cessation Counseling Session**

A cessation counseling session is the face-to-face patient contact at one of two levels: intermediate (greater than 3 minutes and up to 10 minutes), or intensive (greater than 10 minutes). During a 12-month period, the physician and the beneficiary have the freedom to choose between intermediate or intensive counseling strategies for each session.

**Check Codes Carriers Accept**

In March 2005, the Centers for Medicare and Medicaid Services (CMS) created two G codes for smoking cessation, G0375 and G0376. The G codes have been deleted and replaced by the new CPT® codes. Claims for smoking and tobacco use cessation counseling services should be submitted with a suitable medical necessity code. Diagnosis codes should indicate the condition that is adversely affected by tobacco use or the condition treated with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

**Sobering Medicare Rules and Coverage**

Medicare provides coverage of smoking and tobacco-use counseling for beneficiaries who meet one of the following criteria:

- Use tobacco and have a disease or an adverse health effect due to tobacco use; or
Take a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on Food and Drug Administration (FDA)-approved information.

Medicare will cover two cessation attempts per year.

Each attempt may include a maximum of four counseling sessions.

The total annual benefit covers up to eight cessation counseling sessions in one year.

The beneficiary may receive a further set of eight counseling sessions during a second or subsequent year.

A cessation counseling attempt includes the following: up to four cessation counseling sessions (one attempt = up to four sessions) and two cessation counseling attempts (or up to eight cessation counseling sessions) are allowed every 12 months (for example, if the first of eight covered sessions was performed in July 2007, a second set of eight sessions may begin in July 2008).

Beneficiaries must be competent and alert at the time services are provided.

These eligible beneficiaries are covered under Medicare Part B. The coinsurance or co-payment applies after the yearly Medicare Part B deductible has been met.

In 1980, a World Health Organization (WHO) committee stressed the need for efficient methods to identify people with harmful and hazardous alcohol consumption before apparent health and social consequences arise. Alcohol screening, assessment, and intervention are difficult and time consuming, and only two to three people out of 1000 screened benefit from them. In the case of a positive screening result, the physician makes a more detailed assessment of the patient's drinking.

If the assessment confirms the screening result, the patient receives a brief intervention, typically comprising of:

- Feedback on present drinking habits
- Information on health risks of hazardous drinking and on the benefits of sensible drinking
- Advice to cut down or avoid binge drinking

Diagnosis codes should indicate the condition that is adversely affected by tobacco use or the condition treated with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

Self help materials are often supplied and follow up consultations offered.

Use Codes Sensibly

CPT® codes 99408 and 99409 were introduced in CPT® 2008. Research shows that using the new codes will be very cost-effective.

For Medicare services, the following HCPCS Level II codes should be used:

- **G0396** Alcohol and/ or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes
- **G0397** Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes

Medicare has announced that it will not pay for the new CPT® codes as the description of the code includes a screening service, which it does not cover. Medicare also created two new G codes that are nearly identical to the CPT® codes, but has changed the word “screening” to “assessment.” Private insurers may pay for the CPT® codes for this service, but are unlikely to use the G codes. Now in 2008, physicians have four different codes for screening and brief intervention (SBI). Two of the codes are for privately insured patients (99408 and 99409), and two for Medicare patients (G0396 and G0397).

CMS announced two new HCPCS Level II procedure codes for Medicaid services, effective Jan. 2008:

- **H0049** Alcohol and/or drug screening
- **H0050** Alcohol and/or drug services, brief intervention, per 15 minutes

Research reveals that physicians can play a positive role in influencing patients' health decisions about substance abuse. Screening and brief intervention can help to change an individual's harmful drinking and smoking when offered by primary care physicians or in trauma settings. Although these intervention services may be helpful; when reporting the new codes, reimbursement from insurers is not always guaranteed.

Meera Mohanakrishnan, MSc, CPC, has more than four years of experience in the coding field. She holds a masters in biochemistry and is a coding manager at Sysinformation Healthcare Pvt Ltd., Mysore, India. Please contact Meera at m_mkssk@yahoo.com.
Marge Carney, CPC, CGCS
Coding and document manager in St. Louis, Mo.

Coding Edge (CE): Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.?

Marge: I worked for a major hospital in the St. Louis area for 25 years before joining a private physician’s practice. Although I was familiar with the medical field, I had not ventured into the coding and billing aspects until I assumed this role. With the encouragement and support of the physician I work for, I studied for my CPC® exam and later that year I took the specialty credentialing exam.

CE: What is your involvement level with your local AAPC chapter?

Marge: I am currently serving as president of the St. Louis chapter. I first became involved with AAPC members in 2006 when the national conference was held in St. Louis. I was chairman of setting up the Hospitality Room hosted by our local chapter. It was exciting to work with the AAPC and coordinate an event that brought enjoyment to so many visitors. The following year, I served as secretary when our secretary resigned and then advanced as president-elect.

We have a large membership base in the greater St. Louis metropolitan area and I enjoy the challenge of meeting the needs of our members. This year, we are providing new educational opportunities for our members. Our Points for Education program will help us provide CEUs while giving back to the members. We now have a monthly newsletter to increase communication and are redesigning our local chapter’s Web site as an enhancement to the AAPC Web site. Our local chapter meetings are both informative and interactive.

CE: What has been your biggest challenge as a coder?

Marge: The biggest challenge is staying current on compliance and coding, and sharing this information with our providers.

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart? Do you approach the physician, or have a monthly meeting?

Marge: Communicate with your physicians. I find they will respect your expertise and guidance when you approach them as one professional to another. We have monthly meetings where updates and issues can be shared.

CE: If you could have any other job, what would it be?

Marge: An event planner is interesting. Actually, any job that brings personal satisfaction and instills a sense of well being is a great way to spend your time.

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

Marge: I collect baskets, bears, and ladybugs. I enjoy scrapbooking, needlework, and basket making. I am a fan of the St. Louis Cardinals baseball team and I enjoy attending games. My family is very small. I like to spend quality time with my friends who have become my extended family and who are very important to me.
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test yourself

Coding Edge Tests Your Knowledge
August 2008

1. Smoking cessation counseling includes which of the following as part of its steps?
   a. Organizing an emotional family intervention
   b. Sharing cancer literature
   c. Developing a written plan
   d. Referring the patient to an oncologist

2. A lithopedion is also called a:
   a. Kidney stone in ureter
   b. Gall stone
   c. Stone in bladder
   d. Stone baby

3. CPT® code 27416 now allows physicians to code what?
   a. Osteochondral autograft done through open incision on the knee
   b. Osteochondral autograft done through open incision on the shoulder
   c. Osteochondral autograft done through scope on the elbow
   d. Osteochondral autograft done through scope on the knee

4. Scribing is:
   a. A billable service with the right modifier
   b. Not a billable service
   c. A billable service if the physician really has that many patients
   d. Not a billable service if the scribe isn’t a medical transcriptionist

5. Ultrasounds do not include what elements of high-stake pregnancy billing?
   a. Supplies such as gels used during the scan
   b. Pre-and post-operative elements
   c. Monitoring of the fetal heartbeat
   d. Use of the ultrasound machine

6. CPT® code 93325 is for color flow studies. What does this mean?
   a. The ability to change the image’s colors for the family
   b. The ability to label blood cells moving toward and away from the transducer
   c. The ability to label various vessels by vascular family
   d. The ability to label occluded arteries for later study

7. Incident and corrective action reports provide which of the following:
   a. Documentation that problems were identified and corrected
   b. Protection during an investigation
   c. A vital element of your compliance plan
   d. All of the above

8. You must use the new and changed 2009 ICD-9-CM codes beginning what date?
   a. January 1, 2009
   b. July 1, 2008
   c. October 1, 2008
   d. November 1, 2008

9. Split/shared visit rules relate to what issue?
   a. Correct Coding Initiative
   b. End stage renal disease
   c. Incident-to
   d. Capitation

10. New ICD-9-CM codes detail which condition?
    a. MSSA colonization
    b. Migraines
    c. Fetal complications
    d. All of the above
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