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Peggy Y. Green, CMA, CPC, CPC-I, CPMA

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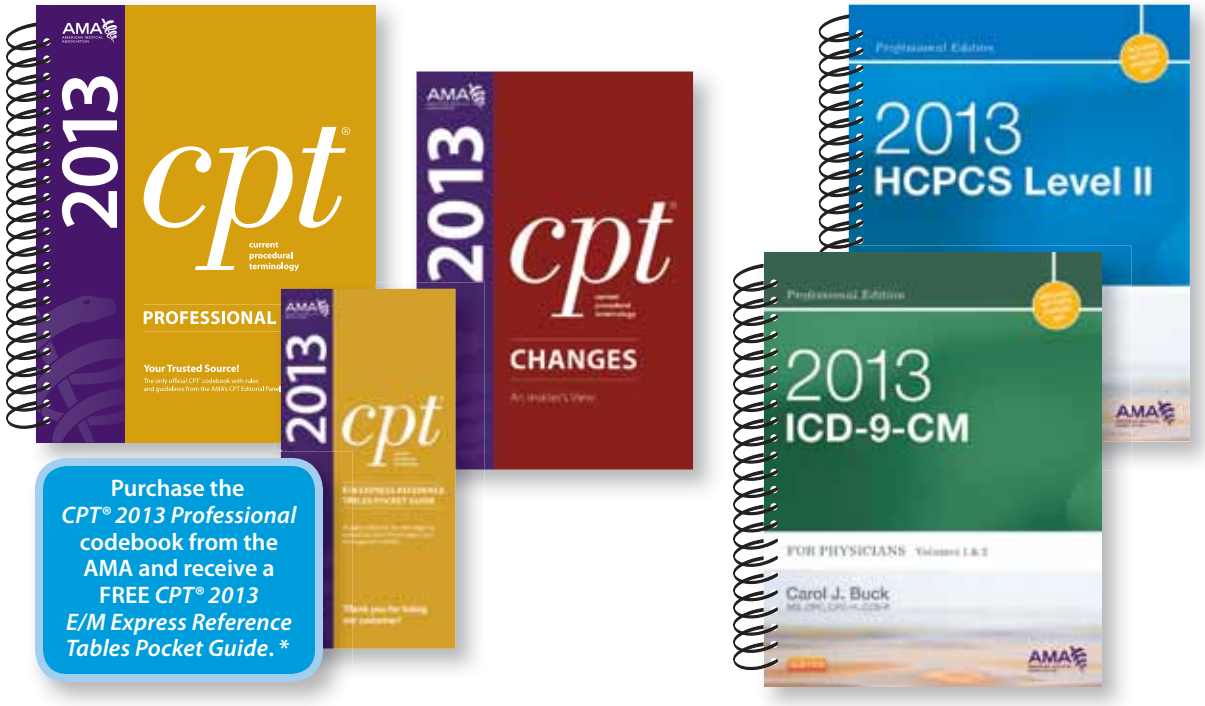

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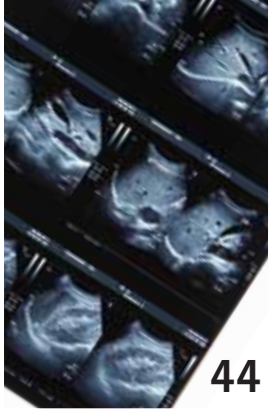

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CODING edge
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On the Cover: *For* **Peggy Y. Green, CMA, CPC, CPC-I, CPMA**, *AAPC 2011 Member of the Year, many doors have opened in her coding career. This grandiose door is at Berry College in Rome, Ga. Cover photo by Connie Locklear Photography (www.locklearphotos.com).*

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5/16 - 5/17	Boston, MA
6/6 - 6/7	Fairfax, VA

2012 Class Date	Class Location
6/27 - 6/28	Cincinnati, OH
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- ICD-10-CM
- Neurovascular Interventional Coding
- Cardiovascular and Thoracic Anesthesia Billing
- Incident-to and Split/Shared Billing
- GI
- Cardiology

Agenda will be available online by May 15, 2012

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Members Are the Life of AAPC

This time of the year our membership enjoys a spring-like growth of enthusiasm.

It starts at AAPC National Conference, this year held in April in Las Vegas. More than 2,000 members attended sessions, networked, and recharged themselves, learning new things about coding, their peers, and themselves. Attendees rubbed shoulders with AAPC leaders and coding experts, and discovered the leaders and experts in themselves. **Brad Barton, CSP**, keynote speaker at this year's national conference, said we should "discover the magic in us," and become more than we thought we could be. He encouraged us to move beyond self-perceptions and illusions, and see what is truly possible.

Members share this attitude at the local level. This is May MAYnia month, when we are all reminded of the unique importance of our more than 500 local chapters. These local groups are the core of AAPC, and they offer you a chance to meet, learn, and laugh regularly with other members in your area. Take advantage of your chapter meeting this month and participate in special activities celebrating AAPC's network of local chapters. Resolve to serve your chapter as an officer, a speaker, or as a mentor to new coders.

Peggy Green CMA, CPC, CPMA, CPC-I, is an example of what I'm talking about. Peggy is our Member of the Year, and says coding has opened many doors for her; and, in turn, she helps open many doors for others. She's pursued a career of excellence and advancement while encouraging others to join her not only in coding, but at her Rome, Ga. local chapter. Peggy serves as an energetic officer and as a proctor for exams. She recruits colleagues to attend while helping new coders get started in the industry. Peggy is pretty excited about her colleagues, coding, and AAPC.

Another example is our Chapter of the Year, the **Springfield, Mo. local chapter**. Recognized at national conference and to be featured in the June *Coding Edge*, the Springfield chapter already earned a national reputation for member participation and spirit when nearby Joplin was torn apart by a mile-wide tornado with estimated winds of more than 250 miles per hour. A third of the town was destroyed, and members of AAPC's Joplin local chapter lost family members, houses, and possessions. The Springfield chapter contacted chapters in a four-state region to solicit cash and other help, and then went to Joplin to help AAPC members and other residents clean up and start again.

This is what AAPC is: a membership of more than 114,000 people who are passionate about coding, billing, auditing, practice management, and their communities. We are anxious to learn and teach; fastidious in the quest for accuracy; and supportive of each other.

Members are the life of AAPC. Congratulations to Peggy and the Springfield chapter, to those who presented at and attended the AAPC National Conference, and to those of you who make the most of May MAYnia at your local chapters this month.

Your Friend,

Reed Pew
Chairman and CEO

This is May MAYnia month, when we are all reminded of the unique importance of our more than 500 local chapters.

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May 3	Jackson, Mississippi	Jun 14	Minneapolis, Minnesota	Jul 26	Tulsa, Oklahoma
May 10	Ft. Lauderdale, Florida	Jun 14	Morgantown, West Virginia	Aug 2	Alburquerque, New Mexico
May 10	Colorado Springs, Colorado	Jun 14	Sacramento, California	Aug 2	Tucson, Arizona
May 10	Chicago, Illinois	Jun 21	Birmingham, Alabama	Aug 2	Salt Lake City, Utah
May 17	Charlotte, North Carolina	Jun 21	Mesa, Arizona	Aug 9	Des Moines, Iowa
May 17	Cincinatti, Ohio	Jun 21	Portland, Oregon	Aug 16	Irvine, California
May 17	Baltimore, Maryland	Jun 21	Monmouth, New Jersey	Aug 23	Virginia Beach, Virginia
May 31	San Antonio, Texas	Jul 12	Indianapolis, Indiana	Aug 23	Cleveland, Ohio
May 31	Boston, Massachusetts	Jul 12	Boise, Idaho	Aug 23	St. Louis, Missouri
Jun 7	Newark, New Jersey	Jul 19	Denver, Colorado		
Jun 7	Portland, Maine	Jul 19	Seattle, Washington		
Jun 7	Bakersfield, California	Jul 26	Milwaukee, Wisconsin		

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Dedication Goes a Long Way

Selecting AAPC's Member of the Year is always an exciting process for the National Advisory Board (NAB). Reading the nomination letters and learning about the achievements, contributions, and selfless acts of our members is inspiring to us.

2011's award recipient, **Peggy Y. Green, CMA, CPC, CPC-I, CPMA**, has qualities we all strive to possess. She has shown a level of dedication that is exemplary.

Peggy's accomplishments are many (see page 28 for a detailed description), and there is no question that she is an outstanding leader, role model, and coding expert. But Peggy possesses other qualities I admire, which strike me as essential in the day-to-day work and coding education environment. These qualities are: "fills in at the last minute," "is very flexible," and "is easy to get along with."

These are personality traits that go a long way in helping yourself and others personally and professionally. Take a moment to consider how you might incorporate these qualities into your local chapter, workplace, or at a job interview.

Fills in at the Last Minute

Local chapter: Sickness, car trouble, winning the lottery, etc. are part of life. When speakers, proctors, and local chapter officers run into these unforeseen circumstances, it's good to know there is a person who can get the job done. Step outside of your comfort zone and you may discover talents you never knew existed.

Workplace: Filling in for others will help you learn new skills in your medical setting. You will also earn brownie points with your coworkers if you go to bat for them. And the next time you want to go to a national conference or a seminar, it will be easier to find someone to fill in for you.

Job interview: If an employer knows they can count on you in a pinch, then you are an asset to their team. When the time is right in an interview, explain a job-related situation where your willingness to step up at the last minute saved the day. Dependability shows you are there to get the job done and you won't let your boss down.

Very Flexible

Local chapter: When organizing speakers, flexibility will help you think outside the box and bring in diverse topics. Accommodating chapter members' needs may require a degree of flexibility as well, but the pay off is that they'll keep coming back.

Workplace: Flexibility is the key to survival in any work environment, especially coding. You must be able to accept new health care regulations, coding changes, and follow compliance rules.

Job interview: An employer wants to know if you are adaptable, versatile, and able to handle any task, position, schedule, or environment assigned to you. Employers are looking for candidates who can wear many hats. If you appear too flexible and willing to take any job, however, you may come across as having a lack of focus. The interviewer may interpret excessive flexibility as "not passionate enough about the position." Show that you love the medical field and that your flexibility and skills can help you reach the goal of being a coder.

Easy to Get Along With

Local chapter: If you are "easy to get along with," you are approachable, and networking is a breeze. People come to you for coding advice and are quick to lend you advice. This quality is great to have if you are a chapter officer because others gravitate toward people they feel comfortable around.

Workplace: When you need to discuss a documentation issue with a doctor, he or she is more likely to listen if the two of you get along, and you listen and aren't confrontational. And, other staff members will be quick to share coding changes with you if they see you as an approachable resource.

Job interview: A smile and positive demeanor go a long way to get you a job. If the interviewer sees that you are easy to get along with, he or she will want his or her employees to work with you. People who possess this quality are team players.

Congratulations Peggy, and thanks for your hard work!

Best Wishes,

Cynthia L. Stewart

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

Take 90 More Days to Work Out the Kinks in ASC X12 Version 5010

The enforcement discretion period for payers and providers to fully adopt the ASC X12 Version 5010 claim reporting standards is extended through June 30, the Centers for Medicare & Medicaid Services (CMS) announced in a March 15 press release. This means CMS will not initiate enforcement action for an additional three months.

CMS' Office of E-health Standards and Services (OESS), however, warns the extension is an opportunity to resolve lingering implementation issues, test systems, and training staff. Another extension is unlikely. Entities required to adopt the new standard are encouraged to solve collaboration problems and begin using the 5010 standard as soon as possible. Support and testing will be stepped up before July 1.

For a slow, successful adoption of the Version 5010 standard by Jan. 1, OESS announced in November 2011 that health plans, clearinghouses, providers, and software vendors were encouraged to complete implementation, testing, and training during a 90-day non-enforcement discretion period.

CMS says steady progress is being made by payers and other entities toward implementation, citing successful receipt and processing for 70 percent of all Part A and 90 percent of Part B claims. OESS, however, believes remaining issues warrant an extension to assure full implementation.

CMS says the OESS is stepping up its existing outreach to include more technical assistance for covered entities. The office is working with several industry groups to help payers, providers, facilities, and suppliers solve technical issues.

To read the press release, go to: www.cms.gov/ICD10/Downloads/EnforcementDiscretionAnnouncement.pdf.

NCCI Quarterly Update Released This Month

The latest National Correct Coding Initiative (NCCI) edits, Version 18.2, is effective July 1 and available through the CMS Data Center. The Recurring Update Notification applies to chapter 23, section 20.9. You can look forward to the release of a test file around May 2, and a final file will be available around May 17.

See CMS Transmittal 2434 for more information (http://www.cms.gov/transmittals/downloads/R2434CP.pdf). *EdgeBlast* or *Coding Edge* will inform you of the updates when the final document is released.

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

Letters to the Editor

Bad Math Botches Body Mass

In the March issue, I noticed an error in the admission short form example on page 34, "From Observation to Inpatient Status: Code the Transition." The patient data indicates that the patient is 6'2" and 185 pounds. The indicated BMI of 32.8 should be 23.8. In addition, under assessment, the physician has indicated "obesity," which is not supported by the data shown.

Barbara Paquin, CPC-A

Good catch! Body mass index (BMI) is an estimate of body fat based on height and weight. BMI does not measure actual body fat and is not a perfect proxy for patient health, but does provide a rough snapshot of body composition for average individuals.

Generally speaking, a BMI of 18.5 to 25 is considered "normal" or "healthy." A BMI of less than 18.5 is considered underweight; a BMI of 25-29.9 is considered overweight; and, a BMI of 30 or above is considered obese.

In our admission short form example, a patient with a BMI of 32.8 would, indeed, be considered obese; however, as you point out, the proper BMI for an individual of 6'2" and 185 lbs is 23.8, which is within the normal, healthy range. To reach a BMI of 32.8, our hypothetical 6'2" patient would have to weigh over 255 lbs.

To calculate BMI in adults, multiply weight by 4.88 and divide the total by the square of height. The mathematical formula is:

BMI = mass (lbs) x 4.88/height $(ft)^2$

If you prefer to skip the math, you can find a variety of easy-to-use BMI calculators online.

— *Coding Edge*

Please send your Kudos to: kudos@aapc.com

Kudos

We ❤ Your License Plate

Check out this one-of-a-kind, coder-rific license plate that AAPC National Advisory Board Member **Cindy Cox, CPC, CPMA**, is sporting.

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By Angela Jordan, CPC, and Brenda Edwards, CPC, CPMA, CPC-I, CEMC

AAPCCA: A Year in Review

Here's a shout out for last year's local chapter accomplishments.

The AAPC Chapter Association (AAPCCA) Board of Directors is a non-profit association established to create, maintain, and sustain local chapter infrastructure through approachable and accountable representation, necessary to empower local chapters to fulfill AAPC's mission to "Uphold a Higher Standard." The Board provides policy, rules, regulations, direction, and advice to AAPC local chapters to ensure they function in accordance with that mission.

The board members are proud of the accomplishments of more than 500 local chapters and the local chapter officers who put the needs of their members first. The 16 AAPCCA members are dedicated to providing chapters with the resources and support they need to be successful.

Let's reflect on last year's AAPCCA accomplishments.

New Chapters? Yes!

Thirty new local chapters were formed across the country in small rural communities and in large metropolitan areas. Despite their locale, one thing they all have in common is they began as a small group of members who saw a need to network and provide education to members in their area.

Handbook Addresses Member Needs

The *Local Chapter Handbook* underwent some major revisions and updates for 2012. The catalyst for the changes came directly from local chapter officers. Each year, the Local Chapter Department and AAPCCA Board receive questions through emails and phone calls regarding chapter business and officer responsibilities. To address those concerns and provide clear direction, the handbook was enhanced to expand on existing responsibilities and duties. These changes were shared with all chapter officers prior to nominations for 2012.

The financial section is another area in the handbook that received added detail and clarification. Chapters struggled with approved methods for earning and spending chapter funds. Information was added to chapters 7 and 13 to provide officers with more concrete processes.

Information on ICD-10 presentations and new criteria for "Chapter of the Year" also were added, and hyperlinks were added throughout the handbook to ease navigation. The result is a clearer, more useful handbook, helping chapters run smoother.

Chapters Pay It Forward

Project AAPC allows chapters to "pay it forward." Since the inception of the program, more than $20,000 has been raised by local chapters for the American Red Cross and Feeding America®. Local chapters have also taken on different charities or projects in their own communities, donating money, as well as volunteer hours. Charitable works included conducting food drives for pantries and homeless shelters, organizing events to help fight cancer, and participating in local disaster relief drives.

Sending the Message Out

The August 2011 issue of *Coding Edge* featured the inaugural column: "Handbook Corner." Since then, board members have contributed seven short articles chock full of information to help AAPC members answer their local chapter questions and navigate through the handbook. Articles varied from obtaining CEUs to proper conduct at local chapter meetings and review classes. AAPCCA Board members have also written other articles for *Coding Edge,* as well as other coding and medical newsletters and magazines.

photobyte/iStockphoto/Getty

We Get Around

We visited 64 local chapters and provided 70 lectures at local chapter meetings and seminars. Our focus in 2012 is to visit even more chapters.

There is a significant increase in the number of members using local chapter forums. All members have access to local chapter general discussion forums and their own individual chapter forums. Officers also have access to the local chapter officers' forum. This is a great place to network, get meeting ideas, and talk to AAPCCA representatives.

The AAPCCA Board puts in more than 4,500 hours of work into their committee, task force, and calls and into researching special projects. Member committees include Handbook, Public Relations, and Local Chapter Development; special tasks forces include Mentoring, Local Chapter Visits, CPC-A®, and Remote Meetings.

Scholarship Program

One accomplishment we are most proud of is the new scholarship program, unveiled during the "Local Chapter Training" leadership session at AAPC National Conference in Las Vegas. This allows ALL chapters to provide current members with an additional resource. The scholarship will help retain members and encourage local chapter leadership by offering assistance to members in times of need.

Thanks for Your Dedication

During the conference in Las Vegas, we said goodbye to our 2011 president, **Melissa Brown, CPC, CPC-I, CFPC, RHIA,** and departing members **Suzanne Fletcher-Petrich, CPC, CPC-P, CPC-I**; **Lynn Keaton Cockrell, CPC, CPC-H, CPC-I, CEMC**; **Lynn Ring, CPC, CPC-I, CCS, CCS-P**; and **Lashelle Bolton, CPC, CPC-H, CPC-I, ROCC**. They will be missed, but their contributions will continue to support local chapters.

Each year, the AAPCCA selects five new board members. If after reading this, you are inspired to help local chapters to grow, please consider applying for the AAPCCA Board when the call goes out in November.

AAPCCA Chair Angela Jordan, CPC, is manager of coding and compliance at EvolveMD by WHN with more than 20 years experience in health care. Her focus is electronic health record (EHR) training, provider education, and documentation audits. Angela received her CPC® in 2000, and is consistently active in her local chapter. She was honored by her peers as "Coder of the Year," "Educator of the Year," and "Networker of the Year" by the Kansas City chapter.

AAPCCA Vice Chair Brenda Edwards, CPC, CPMA, CPC-I, CEMC, has been involved in coding and billing for more than 25 years. She is a coding compliance specialist at Kansas Medical Mutual Insurance Company. Also an AAPC-approved PMCC instructor, workshop presenter, and ICD-10 trainer, Brenda is a frequent speaker for local coding chapters in Kansas and Missouri and has presented at AAPC regional conferences. She is co-founder of the Northeast Kansas chapter.

AAPCCA Handbook Corner

Review Classes Aren't Just for New Coders; Earn CEUs

by Donna Nugteren, CPC, CEMC

Local chapters are to hold at least four Certified Professional Coder (CPC®) exams per year. Many local chapters offer review classes prior to exams. Review classes are usually an in-depth study of the CPT® and ICD-9-CM coding books: how to use them, coding hints, code selection know-how, what in the world to do with a HCPCS Level II code, and whether you should be afraid of catching a disease from anything called HCPCS.

These review classes are approved through AAPC for continuing education units (CEUs), and are not limited to test-takers. Local chapters may offer a review class to individuals who are taking the exam first, but most chapters will open the doors to all chapter members. CEUs may be earned by anyone who takes the class. This is a great way to pick up more CEUs and fine-tune your coding skills. And, for those of you who code for one specialty, it's a great opportunity to venture out and expand your coding knowledge.

It's that time of year again for...

May MAYnia

Spring to your AAPC Local Chapter

Attend your local chapter meeting in May to:

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

Don't want to go alone? Great! Take a friend and help your chapter win prizes and national recognition. (Non-members welcome!)

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

Find your Local Chapter by visiting: www.aapc.com/MAYNIA

SPRING TO YOUR LOCAL CHAPTER
AAPC
May MAYnia

By Annie Boynton, BS, CPC, CPC-H, CPC-P, CPC-I, RHIT, CCS, CCS-P, CPhT

ICD-10 Spotlight: Continue Practice Preparation

The future depends on the specificity that ICD-10 offers.

As *Coding Edge* went to press, Department of Health & Human Services (HHS) Secretary Kathleen Sebelius had just announced a proposed one-year delay of the implementation of ICD-10 to October 1, 2014 from October 1, 2013. Since February, when Centers for Medicare & Medicaid Service (CMS) Acting Administrator Marilyn Tavenner said CMS would "re-examine" the implementation timeline, there has been a lot of industry chatter regarding ICD-10. Many have been asking, "Where do we go from here?" While others, knowing there are hundreds of millions of dollars at stake, are pushing forward with implementation. This is a smart move. ICD-10 is coming, and we need to be ready.

What Should Practices Do About ICD-10?

At this point, there is only one viable option: Continue moving forward with implementation. Any practice that equates a "re-examination" with a "termination" is putting itself at significant risk. Physicians and practice administrators should carry on with ICD-10 implementation plans, keeping a watchful eye on the Oct. 1, 2013 mandate.

Much of the information regarding ICD-10 in the marketplace is full of doom and gloom, and often is based on inaccurate or anecdotal data. In fact, ICD-10 does offer physicians benefits.

Value-based Purchasing Relies on ICD-10's Specificity

Value-based purchasing is one concept that is not often heard in the medical practice, but—as any doctor who has argued an unspecified or miscellaneous code will tell you—it is a concept essential to accurate reimbursement. Value-based purchasing enables more accuracy in payment, based on the specificity in the ICD-10 codes. For example, compare the following ICD-9-CM and ICD-10-CM fracture codes:

ICD-9-CM Fracture Codes:

813.5 Fracture of lower end of radius and ulna open

813.50 Fracture of lower end of forearm, unspecified

813.51 Open Colles' fracture

813.52 Other open fractures of distal end of radius (alone)

813.53 Open fracture of distal end of ulna (alone)

813.54 Open fracture of lower end of radius with ulna

ICD-10-CM Fracture Codes:

S52.57 Other intraarticular fracture of lower end of radius

S52.571 Other intraarticular fracture of lower end of right radius

S52.571A Other intraarticular fracture of lower end of right radius, initial encounter for closed fracture

S52.571B Other intraarticular fracture of lower end of right radius, initial encounter for open fracture type I or II

S52.571C Other intraarticular fracture of lower end of right radius, initial encounter for open fracture type IIIA, IIIB, or IIIC

S52.571D Other intraarticular fracture of lower end of right radius, subsequent encounter for closed fracture with routine healing

S52.571E Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with routine healing

S52.571F Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing

S52.571G Other intraarticular fracture of lower end of right radius, subsequent encounter for closed fracture with delayed healing

S52.571H Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with delayed healing

S52.571J Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing

S52.571K Other intraarticular fracture of lower end of right radius, subsequent encounter for closed fracture with nonunion

S52.571M Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with nonunion

S52.571N Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion

S52.571P Other intraarticular fracture of lower end of right radius, subsequent encounter for closed fracture with malunion

S52.571Q Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with malunion

S52.571R Other intraarticular fracture of lower end of right radius, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion

S52.571S Other intraarticular fracture of lower end of right radius, sequela

The comparison of the code descriptions easily demonstrates the increased specificity in the ICD-10-CM code, and also demonstrates the greater incremental value of the ICD-10-CM code. This specificity will be an important part of value-based purchasing incentive

Any practice that equates a "re-examination" with a "termination" is putting itself at significant risk.

programs in the future, and will help to more accurately demonstrate outcomes of care. Value-based pricing can help payers create reimbursement systems that are more targeted, which can mean more accurate reimbursement in the long term.

Importance of External Cause vs. Condition Codes

ICD-10 specificity is often the focus of media attention. One prominent example was the September 2011 *Wall Street Journal* article, "Walked into a Lamppost? Hurt While Crocheting? Help Is on the Way." The article's focus was on ICD-10-CM external cause codes. There is a code for an injury while crocheting (Y93.D1 *Activity, knitting and crocheting*), for being struck by an orca (W56.22XA *Struck by orca, initial encounter*), for being bitten by a duck (W61.61XA *Bitten by duck, initial encounter*), and even for sustaining injury while milking an animal (Y93.K2 *Activity, milking an animal*). But consider how often the average medical practice reports external causes in ICD-9-CM. The answer is rarely, and that is not likely to change much in ICD-10-CM.

Although the external cause and place of occurrence codes make for entertaining reading, the focus of specificity must be brought to the condition codes. For example, ICD-9-CM contains one code for male breast cancer, while ICD-10-CM has 19 codes to provide greater anatomic detail and to enable monitoring that has been impossible with ICD-9-CM. From a data, quality monitoring, and outcomes perspective, specificity counts.

Procedure Code Benefits

ICD-10 offers similar advantages on the procedure code side. ICD-10-PCS offers specificity that will be vital in analyzing outcomes or care. For example, in ICD-9-CM, there is a single angioplasty code (39.50 *Angioplasty of other non-coronary vessel(s)*). In ICD-10-PCS, there are over 800 angioplasty codes, each one with the vessel, location, method of approach, and device included in the code description. This means physicians and facilities will be able to more accurately represent the work they are performing; and that means, in time, we'll see more accuracy in payment and pricing structures and incentive programs, as well.

Every Bit Helps

ICD-10-CM also supports reductions in administrative costs. Don't scoff: The specificity in ICD-10 offers up real potential for reductions in medical record requests and administrative costs associated with copying and mailing records or supporting documentation. With the highest percentage of gross domestic product (GDP) allotted to health care of any country on the planet, the United States would benefit from even small reductions in administrative costs.

Carry On

What's the bottom line? Continue on the ICD-10 implementation path. Health care has always centered on change. Improving health care reimbursement and care delivery systems, while evolving scientifically and technologically, are not new concepts. If we truly seek better, more affordable health care, then quality improvement, documentation, and data analysis in the future will depend on the specificity that ICD-10 offers.

Let's keep calm, and carry on.

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A&P Quiz

By Rhonda Buckholtz, CPC, CPMA, CPC-I

Think You Know A&P? Let's See …

Type 1 diabetes can occur at any age, but is most often diagnosed in children, adolescents, or young adults. Symptoms of type 1 diabetes include:

- Being very thirsty
- Feeling hungry
- Feeling tired or fatigued
- Having blurry eyesight
- Losing the feeling or having a tingling sensation in your feet
- Losing weight without trying
- Urinating more often

The exact cause of type 1 diabetes is unknown. Most likely it is an autoimmune disorder, which can be inherited. An infection or another trigger causes the body to mistakenly attack the cells in the pancreas that make insulin.

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

Q: Insulin is needed to:

a. Build glucose
b. Store beta cells
c. Produce hormones
d. Move blood sugar

(The answer is somewhere in this magazine.)

Rhonda Buckholtz, CPC, CPMA, CPCI, is vice president of ICD-10 Training and Education at AAPC.

By Shelly Cronin, CPC, CPMA, CANPC, CGIC, CGSC

End the CEU Conundrum

Define, locate, and monitor hard-earned CEUs.

Getting lost in the excitement (or nausea) of taking a certification exam is what happens after you pass. Most members forget that once they earn their credentials their work isn't done; continuing education units (CEUs) are due every two years for all active, credentialed members.

CEUs are required to show certified coders are staying current on new coding- and medical-related information. To assist you in ending a CEU conundrum, let's look at questions most members have, including defining, locating, earning, and monitoring CEUs.

What are the types of CEUs?

Education curriculum must be comprised of core educational content, which is something AAPC credentialed coders do at the core of their day-to-day practice. AAPC has designated two types of CEUs, Core A and Core B type education.

Core A education encompasses a variety of different areas such as coding and billing topics, clinical content, compliance, regulatory topics, data and claims, and payer curriculum.

Core B educational content addresses professional self-improvement, which may include topics covering communication skills, management skills, time and stress management, employee synergy improvement, Occupational Safety and Health Administration (OSHA), and the Joint Commission (formerly JCAHO). The important thing to remember is that only 33 percent of the total CEUs earned per year can be from Core B-approved content. For example, if you have one core credential, then only 12 of the 36 total CEUs due every two years may be from Core B content.

How can I find and earn CEUs?

There are just as many ways to earn CEU credits as there are core topics. To understand CEUs and learn how to earn them you need to understand the process AAPC uses to provide a large pool of available resources.

A great way to earn CEUs and network with other medical professionals is to attend your local chapter meetings; most are for a nominal fee or completely free. You can set your email alerts to notify you of upcoming chapter events for multiple chapters so you don't miss out on the great education our local chapters provide.

CEUs offered to AAPC members by other companies and organizations require prior approval by AAPC for the CEUs to be valid for our members. To accomplish this, AAPC's CEU Vendor Department reviews and processes all applications submitted for AAPC CEU approval. Once approved, titles can be searched via the CEU Search Tool based on a particular topic, specialty, or location.

Applications submitted by vendors for educational content are presented to AAPC members as live presentations such as seminars, workshops, boot camps, courses, live audio teleconferences, and webinars. Educational content also is offered as recordings and self-study, web-based trainings requiring you to pass a post-test to receive CEUs. This post-test allows AAPC to validate that you listened or completed the educational content of the product. Publications, which can include newsletters, educational books, and magazines, can also be submitted for approved CEUs.

To find AAPC-approved CEUs, the best option is to use the CEU Search Tool at www.aapc.com/medical-coding-education/index.aspx. The CEU Search Tool allows you to search for educational content based on specialty, proximity to your location, and any specific keywords you use to narrow your search. If a title has been awarded specialty CEUs, the orange box in the specialties column indicates the number of specialty credentials awarded for that particular title. If you hover your mouse over that orange box, it lists the actual specialty credentials. There's no guessing whether your specialty has been approved.

There are circumstances where the organization or company may not need to submit an application. For more information, go to the Continuing Education page with CEU information for members at www.aapc.com/medical-coding-education/help/index.aspx. The information regarding CEU matching is at the bottom of the page.

How can I earn CEUs for my specialty credentials and how is that decided?

For curriculum to be awarded specialty CEUs, the content must first be approved as Core A content, then that curriculum content must contain intermediate to advanced expertise (which provides education beyond the basics to qualify for specialty designation). Intermediate to advanced level education educates the member about various topics that include complex case coding, troubleshooting, and auditing techniques, etc. Just as specialties in the medical field can overlap, so too can CEU approvals because one title can have multiple specialties assigned to it.

When an application is submitted, AAPC's CEU Vendor Department reviews all educational content for pre-approval and assigns specialties based on the information provided by vendors.

I don't see the title of an upcoming vendor event in the CEU Search Tool. How do I know if these are AAPC-approved CEUs?

Do not assume that all CEUs are approved by AAPC. Many other

The CEU Search Tool allows you to search for educational content based on specialty, proximity to your location, and any specific keywords you use to narrow your search.

credentialing organizations award CEUs. To be safe, prior to purchase, contact AAPC to verify that we have approved the event or if we have a pending application on file.

Some companies or organizations do not know about submitting applications for pre-approval with AAPC. If you have or know about an event that you feel will qualify for CEUs, contact the event coordinator and inform him or her of your interest in earning CEUs for attending the event.

If I teach at a post-secondary school, may I have CEUs for teaching?

An instructor at a post-secondary school may receive up to 16 CEUs per core credential during a two-year renewal period for teaching a face-to-face course specific to the credential. This requires prior approval and an application submission. All instructor applications are submitted under the college's name for review. These CEUs are awarded to the instructor only, so they would not be valid for attendee/student use. Instructors submit the application. If you are an instructor, you will be required to submit your course syllabus, the titles of all curricula, and the start and finish dates of the course.

These are just a few of the questions members have about obtaining and maintaining CEUs. It is the responsibility of every AAPC member to locate and earn his or her CEUs for credential maintenance. Credential maintenance includes monitoring the number of CEUs you have earned by using the CEU Tracker on the AAPC website and being mindful of your renewal dates. Remember: Just as it is important for you to earn your credentials, it is also important to know how to maintain them.

Shelly Cronin, CPC, CPMA, CANPC, CGSC, CGIC, is AAPC's CEU Vendor Department manager.

By G.J. Verhovshek, MA, CPC

Keep Out of Hot Water with Proper POS

Place of service errors are on the OIG hit list, so be sure your coding is up to par.

For the third consecutive year, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) has included place-of-service (POS) errors as an area for review in its annual Work Plan. Judging from the results of several OIG audits over the past decade, POS coding is indeed a serious problem for many practices and facilities. Now's the time to review your own POS coding to ensure you don't become a target for OIG investigation, repayment demands, or worse.

How POS Affects Payment

POS codes are two-digit codes used to indicate the setting in which a health care service was provided. There are approximately 50 POS codes; among the most familiar are 11 *Office*, 21 *Inpatient hospital*, and 24 *Ambulatory surgical center* (ASC). A complete list of POS codes may be found in the *Medicare Claims Processing Manual*, chapter 26, section 10.5 (www.cms.gov/manuals/downloads/clm104c26.pdf). The American Medical Association's (AMA's) *CPT® Professional Edition* also includes a list of POS codes on the page adjacent to the inside front cover.

The coded POS has a direct impact on payment for services provided. As explained in *MLN Matters®* Number: SE1104 (www.cms.gov/MLNMattersArticles/Downloads/SE1104.pdf), "To account for the increased practice expense that physicians generally incur by performing services in their offices and other non-facility locations, Medicare reimburses physicians at a higher rate for certain services performed in these locations rather than in a hospital outpatient department or an ASC."

A correct POS code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of a service performed in a facility setting. On the flip side, an incorrect POS code may result in overpayment if a physician provides a service in a facility setting, but indicates the service was provided in a non-facility setting.

Frequent Errors Raise OIG's Ire

Assigning a POS seems initially straightforward—just determine where the service occurred and key in the correct code. As it turns out, however, POS errors are astonishingly frequent. And at a time when every health care dollar is being squeezed and scrutinized, POS errors have become a very big deal for government payers and auditors.

Assigning POS seems initially straightforward ... As it turns out, however, POS errors are astonishingly frequent.

Takeaways

- Place of service billing errors are a common cause of inappropriate physician payments, and as such are a target for payer audits and the OIG.
- Place of service codes must match the setting where the beneficiary receives the face-to-face service.
- Billable, non-face-to-face services are billed to the place of service Where the beneficiary received the technical portion of the service.

As an example of how pervasive POS errors are, the OIG audited select claims for a single payer (TrailBlazer Health Enterprises, LLC) for the two-year period Jan. 1, 2001-Dec. 31, 2002. Of those claims audited, 67 percent contained POS errors. From this, the OIG estimated TrailBlazer overpaid physicians $1,051,477 over the 24 months. In another audit involving claims submitted to National Heritage Insurance Company (NHIC) during 2002-2003, 81 percent of sampled claims contained POS errors. The OIG estimated that for all claims during the sample period, NHIC had overpaid physicians a total of $4,254,613 due to inappropriate POS codes.

In the results of a third audit published in 2010, the OIG estimated that Medicare contractors nationwide overpaid physicians $13.8 million during 2007 due to POS errors. An incredible 90 percent of claims sampled during the audit contained POS errors, in which physicians used non-facility POS codes on their claims for services that were actually performed in hospital outpatient departments or ASCs.

Partly as a result of these audits, the OIG has included POS errors as an area of investigation in its annual Work Plan since 2010. The 2012 Work Plan specifies, "We will review physicians' coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service" (http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf).

The message from the OIG is clear: A crackdown of POS errors is underway.

Avoid POS Problems

The OIG identified several factors as the most common causes of POS errors:

- Default physician billing software settings
- Physicians' billing personnel or agents were confused about the precise definition of a "physician's office," or were following established practice in applying the office POS code
- Physicians' billing agents were unaware that an incorrect POS code could change the Medicare payment for a specific service
- Personnel made isolated data entry errors

In other words, most errors are mistakes rather than intentional efforts to gain overpayments—but that won't prevent payers from seeking repayments if they find POS errors (in fact, seeking repayments is exactly what the OIG has suggested payers do). The good news is: The best way to prevent POS errors may be simple awareness of the problem.

All coding and billing personnel must know that POS codes affect reimbursement. POS codes should be double-checked prior to claims submission, and POS coding should be part of your internal auditing process. If possible, change billing software so the POS does not default to "physician office,"

POS = Location Where Patients Receive Service

Per the Centers for Medicare & Medicaid Services (CMS) Transmittal 2407, the place of service (POS) code for all physicians paid under the Medicare Physician Fee Schedule (MFPS) must match the setting in which the beneficiary receives the face-to-face service. Billable, non face-to-face services (such as when a physician interprets diagnostic test results) are billed to the POS in which the beneficiary received the technical portion of the service.

As an example, *MLN Matters*® Number: MM7631 offers the following scenario:

"A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC [technical] portion of the MRI. The physician furnishes the PC [professional] portion of the beneficiary's MRI from his/her office location. POS code 22 [outpatient hospital] will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital."

There are two exceptions to the rule that says the physician always uses the POS code where the beneficiary is receiving care as a hospital inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service.

1. When a physician, practitioner, or supplier provides services to a patient who is an inpatient of a hospital, the inpatient hospital POS code 21 will be used irrespective of the setting where the patient actually receives the face-to-face encounter.
2. Physicians or practitioners who perform services in a hospital outpatient department will use POS code 22 (outpatient hospital) unless the physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.6. Use of POS code 11 (office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

References: Transmittal R2407CP (www.cms.gov/transmittals/downloads/R2407CP.pdf) and *MLN Matters*® Number: MM7631 (www.cms.gov/MLNMattersArticles/Downloads/MM7631.pdf).

Facility and Non-facility Places of Service

The list of settings where physician's services are paid at the facility rate include:

- **21** · *Inpatient hospital*
- **22** · *Outpatient hospital*
- **23** · *Emergency room-hospital*
- **24** · *Ambulatory surgical center*: Physicians are not to use POS code 11 (office) for ASC services *unless* the physician has an office at the same physical location of the ASC that meets all other requirements for operating as a physician office at the same physical location as the ASC—including meeting the "distinct entity" criteria defined in the *ASC State Operations Manual*—and the service was actually performed in the office suite portion of the facility.
- **31** · *Skilled nursing facility* (SNF) for a Part A resident
- **34** · *Hospice*, for inpatient care: For services provided to a hospice beneficiary in an outpatient setting, such as the physician/non-physician practitioner's (NPP) office (POS 11); the beneficiary's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital (POS 22)), the patient's physician or NPP or hospice independent attending physician or NPP, will assign the POS that represents that setting, as appropriate.
- **41** · *Ambulance – land*
- **42** · *Ambulance – air or water*
- **51** · *Inpatient psychiatric facility*
- **52** · *Psychiatric facility – partial hospitalization*
- **53** · *Community mental health center*
- **56** · *Psychiatric residential treatment center*
- **61** · *Comprehensive inpatient rehabilitation facility*

Settings where physician services are paid at non-facility rates include:

- **01** · *Pharmacy*
- **03** · *School*
- **04** · *Homeless shelter*
- **09** · *Prison/correctional facility*
- **11** · *Office*
- **12** · *Home or private residence of patient*
- **13** · *Assisted living facility*
- **14** · *Group home*
- **15** · *Mobile unit*: If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. If the mobile unit is not serving an entity that could be described by an existing POS code, the providers are to use POS 15. Medicare will apply the non-facility rate to payments for services designated as being furnished in POS 15 and apply the appropriate facility or non-facility rate for the POS code designated when a code other than the mobile unit code is indicated.
- **16** · *Temporary lodging*
- **17** · *Walk-in retail health clinic*
- **20** · *Urgent care facility*
- **25** · *Birthing center*
- **32** · *Nursing facility* and SNFs to Part B residents
- **33** · *Custodial care facility*
- **49** · *Independent clinic*
- **50** · *Federally qualified health center*
- **54** · *Intermediate care facility/mentally retarded*
- **55** · *Residential substance abuse treatment facility*
- **57** · *Non-residential substance abuse treatment facility*
- **60** · *Mass immunization center*
- **62** · *Comprehensive outpatient rehabilitation facility*
- **65** · *End-stage renal disease treatment facility*
- **71** · *State or local public health clinic*
- **72** · *Rural health clinic*
- **81** · *Independent laboratory*
- **99** · *Other place of service*

but rather requires that billing personnel enter the POS. If you use a third-party billing company, alert them that POS errors are on the radar for payers and the OIG.

Above all, providers should verify that they are reporting the POS code that applies to the setting in which the service was provided, and that the submitted procedure code is compatible with that POS. For example, Office or Other Outpatient codes (procedure codes 99201-99215) should be billed with POS codes 11 *Office*, POS 22 *Outpatient Hospital*, etc., whereas home service (99341-99350) should be billed with POS 12 *Home*.

Clear Guidance on POS Definitions

Occasionally, a POS error occurs because of genuine confusion over exactly how the POS is defined. For example, what is the POS if a physician leases office space from an ambulatory surgery center (ASC)? If a physician sells his or her practice to a hospital, is the office location still considered freestanding for reimbursement purposes?

To clarify POS definitions, observe the following guidelines:

- An office (POS 11) is a location where the physician (or group) pays all of the overhead expenses, including rent (or mortgage), staff salaries, supplies, utilities, etc.
- In an outpatient hospital (POS 22), the hospital employs the staff, owns the space, and incurs all of the overhead expenses. The hospital bills a facility fee to cover the cost of

All coding and billing personnel must know that POS codes affect reimbursement.

Hospital

the expenses. Outpatient hospital locations include the observation unit, outpatient surgery unit, endoscopy suite, and hospital clinics.

- An emergency room (POS 23) is a hospital location where emergency diagnosis and treatment of illness or injury is performed. The hospital charges a facility fee to cover the overhead costs.
- An inpatient hospital (POS 21) includes all services provided to a patient that has been formally admitted to the hospital. All overhead expenses are billed through the hospital.
- An ASC (POS 24) is certified by Medicare to perform designated surgical procedures. The ASC bills a facility fee to cover the cost of overhead associated with the procedures. Laboratory and radiology services, other than those performed to assist in a procedure, are not permitted in the ASC during the ASC hours of operation. Other non-surgical services, imaging, infusions, or diagnostic procedures not on Medicare's list of ASC-approved services should not be performed in the facility.

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By Marvel J. Hammer, RN, CPC, CCS-P, CHCO, ACS-PM, and G. John Verhovshek, MA, CPC

Complete, Current Pain Management

Part 2: Make room for the latest in CPT® coding.

CPT® 2012 has brought important changes to pain management coding. Last month, in the article "Move Over Obsolete Pain Management Coding," we reviewed new coding guidance for sacroiliac (SI) joint injection, "open" versus "percutaneous" disc procedures, single epidural injections, and facet joint nerve destruction. In the second and final portion of this article, we will discuss revised combination codes for pump refill and programming, coding methodology changes for "simple" versus "complex" neurostimulator programming, and more.

Takeaways:

- Review new and revised implanted pump refill and analysis/reprogramming codes, usually reported together.
- Base neurostimulator analysis and program coding on the number of generator parameters changed during the programming session.
- Complex neurostimulator programming is determined by location and total time spent changing parameters.

"New and Improved" Implanted Pump Refill and Reprogramming

According to Medicare review, implanted pump refill and analysis/reprogramming codes are reported together at least 75 percent of the time. As a result, 2012 brings new and revised codes for these services.

Pump Analysis Only: The descriptor for 62367 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill* was revised to clarify the code should be reported only when the provider performs an analysis of the pump setting not in association with either reprogramming or refill.

Pump Analysis and Reprogramming Only: Code 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* was not changed for 2012 and would be reported for analysis and reprogramming not associated with an implanted pump refill.

Pump Refill and Reprogramming: New code 62369 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill* is reported for programmable implanted pump refill by a non-physician (previously billed using 62368 and 95990).

Pump Refill and Reprogramming by a Physician: Also new for 2012, 62370 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)* is used when a physician refills an implanted, programmable pump and also performs the reprogramming. These services previously were reported with 62368 and 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring physician's skill.*

The implantable pump/reservoir refill codes, 95990 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed* and 95991 have been updated to specify that electronic analysis, when performed, is an included component. These codes will primarily be used for the refilling and maintenance of an implantable non-programmable spinal or brain pump or reservoir.

New parenthetical instructions disallow reporting 62367-62370 with either 95990 or 95991.

Determination of Simple vs. Complex Neurostimulator Programming Changes

CPT® 2012 has revised the section guideline instructions for application of neurostimulator programming codes. Previously, the determination of simple versus complex programming was based on what the generator was capable of affecting. Starting in 2012, section guidelines indicate that neurostimulator analysis and program coding is based on the number of generator parameters that are changed during the programming session.

Neurostimulator Analysis Only: 95970 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming*

Simple Neurostimulator Programming: 95971 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave*

Starting in 2012, section guidelines indicate that neurostimulator analysis and program coding is based on the number of generator parameters that were changed during the programming session.

form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

Simple intraoperative or subsequent programming of the neurostimulator pulse generator/transmitter (95971) includes changes to three or fewer of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time, and more than one clinical feature (e.g., rigidity, dyskinesia, tremor).

Coding for complex neurostimulator programming is determined by location (spinal, cranial, etc.) and total time spent changing at least four of the above-listed parameters:

Spinal Cord or Peripheral Complex Neurostimulator Programming: 95972 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour* and +95973 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)*

Cranial Nerve Complex Neurostimulator Programming: 95974 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour* and + 95975 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)*

Also new for 2012 is a parenthetical note directing providers to append modifier 52 *Reduced services* to 95972, 95974, and 95978 if the programming time is fewer than 31 minutes.

Apply Coding Changes and Guidelines

For example, at a postoperative follow-up visit the physician spends 10 minutes making program changes to the pulse amplitude and pulse frequency for a greater occipital nerve neurostimulator generator inserted six days ago for occipital neuralgia. Proper physician office coding is 95971 (based on only the number of generator parameters changed, not time) with diagnoses of 723.8 *Other syndromes affecting cervical region* and V53.02 *Fitting and adjustment of neuropacemaker (brain) (peripheral nerve) (spinal cord).* Analysis and programming are not considered part of the surgical global package and are separately reportable during the global period.

In a second example, two days post-permanent implantation of two lumbar epidural neurostimulator arrays and a pulse generator, the patient presents to the office for initial programming of the pulse generator. The spinal cord neurostimulator was inserted for complex regional pain syndrome (CRPS) type II of the bilateral lower extremities. The physician spends 45 minutes setting the initial generator parameters for the 16 electrode contacts including rate, pulse amplitude, duration, and frequency. Proper coding would be 95972 with 355.71 *Causalgia of lower limb* and V53.02.

As a final example, a patient presents to the office with complaints of increased pain, questioning if the epidural neurostimulator is working. The spinal cord neurostimulator was initially placed for lumbar post-laminectomy syndrome. The physician performs an analysis of the pulse generator and spends a total of 25 minutes making changes to the following parameters for the eight electrode contacts: stimulation train duration, train spacing, and dose time. In this case, proper coding is 95972-52 (because fewer than 31 minutes are spent reprogramming), 722.83 *Postlaminectomy syndrome; lumbar region* and V53.02.

Marvel J. Hammer, RN, CPC, CCS-P, CHCO, ACS-PM, is owner of MJH Consulting in Denver, Colo.

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

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

ADD and ADHD: Know Their Distinction

Signs and symptoms will determine the type and your code choice.

I am sitting at my desk coding operative reports when the telephone rings. I answer the phone and help a patient with a billing question. When I hang up, my physician asks me a question that sends me in a completely different direction. All the while, I'm answering incoming email. Three hours go by, and it occurs to me that I have yet to finish coding those operative reports.

Is This Multitasking or ADD?

Attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) affect approximately 8 million adults, and possibly 10 percent or more of all school-aged children (statistics vary widely). ADD and ADHD are related diagnoses and are often grouped together, with the distinction that ADHD includes hyperactivity.

My son (now 18) was diagnosed with ADHD at age 5. At age 3, he was like the Energizer Bunny® with an inexhaustible battery—but what 3-year-old boy isn't? By age 4, his "fits" and impulsiveness worsened. Then, on the first day of kindergarten, I received a call from the school. The conversations (and many thereafter) were about my son not sitting still, not paying attention, and shouting out answers to questions that were completely off base.

Eventually, my husband and I decided to take our son to a developmental psychologist. Following six months of a sugar-free, caffeine-free diet and other steps, plus assessment after assessment (by physicians, teachers, and us, his parents), our child was diagnosed with ADHD.

photo by iStockphoto/Sbelkid

Takeaways:

- Attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) affect 8 million adults.
- Though similar, the symptoms differ for these complex diagnoses.
- Two ICD-9-CM codes are used to report the conditions; three ICD-10-CM codes can be applied.

Diagnostic Criteria

When determining a diagnosis of ADHD, physicians are held to the criteria spelled out in the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV), published by the American Psychiatric Association (APA). Research shows that ADD and ADHD have nothing to do with bad parenting, family problems, bad teachers or schools, too much television, or (my favorite) too much sugar.

To substantiate ADHD, the child must have six or more signs and symptoms from one of the two categories below (or, six or more signs and symptoms from each of the two categories).

1. Inattention

- ❑ Often fails to give close attention to details or makes careless mistakes in schoolwork and other activities
- ❑ Often has difficulty sustaining attention in tasks or play activities
- ❑ Often does not seem to listen when spoken to directly
- ❑ Often does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions)
- ❑ Often has difficulty organizing tasks and activities
- ❑ Often avoids, dislikes, or is reluctant to engage in tasks requiring sustained mental effort (such as schoolwork or homework)
- ❑ Often loses things necessary for tasks or activities (for example, toys, school assignments, pencils, books)
- ❑ Often is easily distracted
- ❑ Often is forgetful in daily activities

2. Hyperactivity and Impulsivity

- ❑ Often fidgets with hands or feet or squirms in seat

Research shows that ADD or ADHD have nothing to do with bad parenting, family problems, bad teachers or schools, too much television, or (my favorite) too much sugar.

- ❏ Often leaves seat in classroom or in other situations in which remaining seated is expected
- ❏ Often runs about or climbs excessively in situations in which it is inappropriate
- ❏ Often has difficulty playing or engaging in leisure activities quietly
- ❏ Often is "on the go" or often acts as if "driven by a motor"
- ❏ Often talks excessively
- ❏ Often blurts out answers before questions have been completed
- ❏ Often has difficulty taking turns
- ❏ Often interrupts or intrudes on others (for example, butts into conversations or games)

In addition to having at least six signs or symptoms from one of the two categories, a child with ADHD:

- Has inattentive or hyperactive-impulsive signs and symptoms that caused impairment and were present before age 7
- Has behaviors that aren't normal for children the same age who don't have ADHD
- Has symptoms for at least six months

continued on page 49

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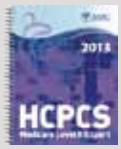 HCPCS Level II	~~$94.95~~	**$44.95** through June 30th
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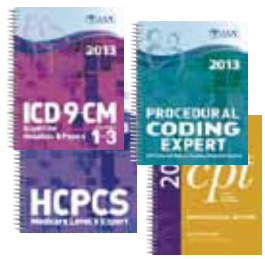

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By Michelle A. Dick

2011 Member of the Year

Coding opens doors for Peggy Y. Green.

Does **Peggy Y. Green, CMA, CPC, CPC-I, CPMA**, promote the coding profession and AAPC? You betcha! Peggy helped to get the AAPC Rome, Ga. local chapter started and has served as the first president, education officer, and member development officer.

Fellow Rome chapter members **Crista J. Kelley, CPC**, and 2012 Secretary **Cynthia W. Lowe, CPC,** can attest to Peggy's dedication to our organization. They said in her nomination letter:

"We believe this is her special calling in life. This year [2011], Peggy recruited 15 members to join the Rome chapter and there are 92 members in total: 34 are her students or have been her students, and 11 are co-workers. Last year [2010], she recruited 12 new members and there were 64 members total in the Rome chapter; 23 were her students and 6 co-workers."

It's not just the numbers that are impressive, it's her character. Crista and Cindy said, "Peggy is thought of very highly, she is respected and she is a great teacher, friend, and co-member. Peggy truly is one of a kind. She sets a high standard of professionalism and higher education."

How It All Began

Peggy began her coding career in 1990 in a small rural county hospital. She worked in the only open position at the time: collections. When the hospital offered to send their coders to a coding class at a nearby community college, Peggy asked if she could go. Because it was not part of her job, the hospital would allow her to go only if she paid for the classes herself.

It was money well spent—she was hooked. She loves solving mysteries and puzzles, which is what coding is to her. She said, it's "solving the mystery of what payers want by coding correctly."

Since Peggy's introduction to coding, she has worked in family practice and gastroenterology practices and is now a coding and reimbursement analyst for Harbin Clinic, LLC., in Rome, Ga. At Harbin, she assists departments with coding issues, researches new procedures for correct coding, shares in teaching a monthly basic coding class to employees, teaches a coding class for all new non-physician providers, meets with new physicians to discuss coding guidelines, helps with audits, and verifies if a denial needs an appeal.

When Peggy was first certified, she entered charges for a single specialty. Since then, her coding knowledge has expanded and when asked coding questions, it's from a wide range of specialties. Peggy said, "My CPC® coding credential enabled me to get a position as an adjunct coding instructor for medical coding at Georgia North-

"Peggy is thought of very highly, she is respected and she is a great teacher, friend, and co-member."

western Technical College," and "my CPC-I® credential has helped me hold CPC® preparation classes for people interested in obtaining their CPC® credentials." She added, "My credentials from AAPC have opened many doors for me." Peggy has been asked to do presentations on coding for various organizations such as the American Association of Medical Assistants (AAMA) and for her local chapter.

Encouragement Goes a Long Way

Peggy had help along her coding journey. She said, "**Shirley Grogan** was the first person to encourage me to pursue this adventure in coding and there have been many others along the way."

Peggy mentions her chapter as being particularly supportive, as well. "The Rome, Ga. chapter has been so encouraging," she said. "Without the support of the members, I could not have accomplished the things that I have." The Rome chapter members feel the same way about her. 2012 Member Development Officer **Christina Ash, CPC**, said, "Peggy has been a wonderful asset to the Rome chapter—she is the reason we now have a Rome chapter."

According to Christina, during the past year Peggy "has spoken at several of our monthly meetings and arranged for other speakers, as well. Peggy has helped organize our yearly seminar and is always willing to lend a helping hand in any activity that we plan … Peggy has had 100 percent involvement with the Rome chapter. She devotes herself to see our chapter succeed."

2011 Coding Accomplishments

According to Crista and Cindy, Peggy is "very active in all walks of chapter life," and has been the foundation and support of the Rome chapter. "Peggy attends all officer meetings and comes prepared with new ideas/suggestions, and how to implement them," Crista and Cindy said. "She is always eager to volunteer in any way she can to help the chapter, chapter members, and AAPC. She is already volunteering before you have to ask her to do something. She has great forethought of what needs to be done and follows through. She is dependable." Crista and Cindy also said that Peggy "fills in at the last minute and is very flexible and easy to get along with."

Another advocate on Peggy's behalf is **Melissa McDaniel, CPC**. She listed Peggy's local chapter and AAPC accomplishments:

- As member development officer, she welcomed members at the monthly meetings and encouraged students to come to meetings. She paired older members with new members and mentored new members.
- She was nominated as the workshop committee chairperson for 2012 and actively participated in planning and executing the plans for each annual workshop.
- She volunteered to teach the Certified Professional Coder (CPC®) exam review class for the Rome chapter several times a year.
- She proctored CPC® exams for the Rome chapter, and arranged for National Alliance of Medical Accreditation Services (NAMAS) to hold a Certified Professional Medical Auditor (CPMA®) workshop for chapter members interested in obtaining that credential.
- She promoted AAPC, by recruiting 15 members to join the Rome chapter this year. Of the 92 chapter members, 34 are or have been her students, and 11 are or have been co-workers. She also spoke to medical assistant students and online coding students concerning the benefits of becoming a member of AAPC.
- She has been a member of the planning committee for teaching ICD-10.
- She taught a 15-week CPC® examination prep class for those interested in sitting for the CPC® credential.
- She brought information back from national conference to share with chapter members who weren't able to attend.
- She contacted Medicare and other payers for information regarding coding and shared answers with others.

Peggy's coding activities outside of her local chapter involve:

- Serving as the local AAMA chapter president.
- Teaching coding at Georgia Northwestern Technical College in Rome since 2004: one semester of ICD-9 coding and one semester of CPT® coding.
- Being a member of the advisory board for Contexo Media for 2011-2012.
- Teaching a monthly class at Harbin Clinic, LLC.
- Researching and helping to keep all 140 providers and their support staff up-to-date on coding changes (Harbin Clinic is the largest privately owned multi-specialty physician group in Georgia with more than 30 different medical specialties and sub-specialties).
- Contributing weekly to ICD-10 education articles.

"Peggy truly is one of a kind. She sets a high standard of professionalism and higher education."

Peggy Up Close

Peggy is married to Donald Green and lives atop of Lookout Mountain in Cloudland, Ga. They have three children, five grandchildren, three cats, and a dog. Donald is retired and they spend a lot of time camping at various state parks in Georgia. They enjoy going to the beach. Between Peggy's job at Harbin and teaching, she doesn't have a lot of spare time. With the little time she has for recreation, she loves to hike, read, cross-stitch, and, of course, spend time with the grandkids.

Peggy's Past 4 Years: Rome Chapter Timeline

2008
Instrumental in forming the Rome chapter

2009
Rome chapter established

Nominated, elected, and serves as the first president

Co-chairs the first annual workshop committee

Initiates chapter meetings and the annual workshop

2010
Serves as education officer and arranges speakers to present for chapter meetings

Recruits 12 new chapter members

2011
Serves as member development officer

Recruits 15 new chapter members

Coding Is Personal

Whether in the classroom or one-on-one, Peggy has a knack for making coders feel welcome and helping them on an individual and personal level. Christina says that Peggy "is always available to answer any coding questions that I may have. I also know that I can refer anyone to her and she will offer a helping hand."

Peggy makes sure all chapter members are comfortable. Crista and Cindy said, Peggy "provides support and is caring. She wants everyone to succeed in what they are trying to accomplish and will do her utmost to assist them in their goal." This year, the Rome chapter had four classes and Peggy took the primary role in making sure those who participated received the information needed to be successful in passing the CPC® exam.

Two years ago, Melissa was a student of Peggy's CPC® Exam Prep class. Melissa recalls her experience with Peggy as her teacher, "I am 100 percent sure that I would have NEVER had the confidence to take the CPC® exam, nor would I have passed it, without Peggy. She is truly a gift to the coding profession and makes it exciting for all who have the privilege of knowing her."

Peggy has even encouraged her family to join the coding world. Her younger sister, **Donna Whitmire, CPC**, said, "I can say that without her help, encouragement, and guidance, I would not have chosen a career in coding."

Donna said that Peggy is a great teacher and always willing to send her information that is beneficial and pertains to her job. Donna said, "I passed my CPC® certification after I had taken a workshop that Peggy offered. She is always ready to help me with any coding issue I have and teaches on a level that I can comprehend."

Keeps on Coding in 2012

Peggy is now in school working to obtain her associate's degree in Health Management and remains highly active in her local chapter, serving as the workshop committee chairman.

In regards to being on the advisory board for Contexo Media, Crista and Cindy say, "Chapter members are very excited and can't wait to hear her thoughts on this new adventure."

Peggy is happy with where coding has taken her. She said, "In my working life, I have had the opportunity to do many different types of work, and I can honestly say I would not want to do anything else beside work in the coding field and teach coding."

Peggy will continue opening doors in the coding community and keeping current with coding changes. She concluded, "It is a career that is constantly changing and you learn something new every day."

Michelle A. Dick is executive editor at AAPC.

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By G.J. Verhovshek, MA, CPC, and Rita Von Holtum, CPC-H

8 Tips Give You Straight Facts on Modifier 33

Weed through the guidance to properly append this commonly confused modifier.

Takeaways:

- Modifier 33 was added in November 2011 to help report preventive care.
- It is to be used when reporting services to private payers only.
- Know the codes to which modifier 33 must be appended.

Nearly 18 months since its introduction at the American Medical Association's (AMA's) 2010 CPT® Symposium, modifier 33 *Preventive service* continues to cause confusion. Here, we review eight quick tips that teach you when and how to append modifier 33.

1. Know Where to Find Information

The AMA published guidance for applying modifier 33 in the December 2010 *CPT® Assistant*, and followed up with brief entries in *CPT® 2012 Changes: An Insider's View* and "Appendix A—Modifiers" of the CPT® 2012 manual. Private payers have also begun to issue guidance on modifier 33 (Search the Web to see if your payer does.).

As *CPT® Assistant* explains, modifier 33 was created in response to the Patient Protection and Affordable Care Act (PPACA), which requires all health care insurers to cover certain preventive services and immunizations without cost sharing. In other words, insurers must waive the co-pay and deductible and pay, in full, for specified covered services. By appending modifier 33, the provider alerts the insurer that a covered preventive service was provided, and that patient cost sharing does not apply.

2. Know Which Services Are Covered

Only select preventive services and immunizations are fully covered under PPACA. You may append modifier 33 to identify preventive services that fall into the following four categories, per AMA instructions:

1. Services rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF). Services with an "A" rating have been judged to have a high certainty that the net benefit is substantial. Services with a "B" rating have been judged to have a high certainty of moderate to substantial net benefit. A listing of these services is updated and posted annually on the Agency for Healthcare Research and Quality's website: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
2. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics), as supported by the Health Resources and Services Administration (HRSA).
3. Preventive care and screenings provided for women (not included in the USPSTF recommendations) in the comprehensive guidelines supported by HRSA. Examples falling into the categories above include HIV screening in adults and adolescents at an increased risk for HIV infection, bacteriuria screening for pregnant women, blood pressure screening in adults, and colorectal cancer screening in adults beginning at age 50.
4. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Examples include Zostavax immunization in adults; inactivated polivirus for children; and hepatitis A and B, human papillomavirus, measles, mumps, and rubella, and influenza for both adults and children.

Nearly five dozen preventive screening and immunization services are covered under PPACA, and may be reported with modifier 33. When reporting a claim with modifier 33, medical records are not required, but must be available upon request.

3. Apply Modifier 33 for Private Payers Only

The Centers for Medicare & Medicaid Services (CMS) has not issued any guidance for modifier 33. There's a good reason for this: Medicare and Medicaid do not recognize modifier 33.

Claims submitted to Medicare containing modifier 33 will be returned with Medicare Outpatient Adjudication (MOA) code MA130, which indicates that the claim contains incomplete and/or invalid information that is "unprocessable." As such, you should only append modifier 33 for non-Medicare payers, as per AMA instructions.

Medicare is not exempt from the requirements of PPACA, and must pay in full for covered services; however, Medicare requires the use of dedicated G codes that specifically describe covered services as preventive (e.g., G0202 *Screening mammography, producing direct digital image, bilateral, all views*). A guide to Medicare-covered preventive services may be found on the Medicare website: www.medicare.gov/Publications/Pubs/pdf/10110.pdf.

4. Turn to 33 for Screening Turned Diagnostic

You may also apply modifier 33 when a preventive service must be converted to a therapeutic service. "The most notable example of this," according

The Centers for Medicare & Medicaid Services (CMS) has not issued any guidance for modifier 33. There's a good reason for this ...

to *CPT® Assistant*, "is screening colonoscopy [45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)*] that results in a polypectomy [e.g., 45383 *Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*]."

Reminder: Apply modifier 33 only for commercial carriers. Medicare does not accept modifier 33. If a screening colonoscopy leads to polyp removal for a Medicare patient, report the appropriate removal code (e.g., 45383 *Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique*) with modifier PT *Colorectal cancer screening test; converted to diagnostic test or other procedure*—rather than modifier 33—appended.

5. Selected Services Covered In-network Only

Insurers are permitted to require cost sharing for those services that are not covered under PPACA. Insurers also are permitted to impose cost sharing—or choose not to provide coverage—for recommended preventive services provided out-of-network. Treatment resulting from a preventive screening is subject to cost-sharing if it is not a recommended preventive service.

6. Apply 33 to All Eligible Services

If a physician provides multiple preventive medical services to the same (non-Medicare) patient on the same day, append modifier 33 to the codes describing each preventive service rendered on that day.

7. Cost Sharing Doesn't Apply for Separate, Same-day Services

The insurer may not impose cost sharing if the primary reason for an office visit is to receive a preventive service; however, per the AMA, cost-sharing is allowed for an office visit if the office visit and covered preventive service are billed separately, and the primary purpose of the office visit is not to deliver the covered preventive service. To illustrate, *CPT® Assistant* provides the following examples:

- "A 45-year-old male individual receives a cholesterol screening test, which is a recommended preventive service, during an office visit for hypertension management. The plan or issuer may impose cost-sharing requirements for the office visit because the recommended preventive service is billed as a separate charge and the office visit was not primarily for preventive services."
- "An individual receives a recommended preventive service that is not billed as a separate charge. The primary purpose for the office visit is a recurring abdominal pain and not the delivery of a recommended preventive service. Therefore, the plan or issuer may impose cost-sharing requirements for the office visit."
- "An individual receives a recommended preventive service that is not billed as a separate charge, ie, it is part of the office visit and the delivery of said service is the primary purpose of the office visit. Therefore, the plan or issuer may not impose cost-sharing requirements for the office visit."

8. Designated Preventive Services Don't Require 33

Do not append modifier 33 for "separately reported services specifically identified as preventive," per CPT® Appendix A. Included in this category are any HCPCS Level II G codes for preventive services, such as G0202 (screening mammography), G0103 *Prostate cancer screening; prostate specific antigen test (PSA)*, and G0389 *Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening*). Use HCPCS Level II codes to describe services provided for Medicare and Medicaid beneficiaries. Use CPT® codes, when applicable, to report services for patients covered by private insurance.

For example, to report a covered screening mammography for a non-Medicare patient, you would report 77057 *Screening mammography, bilateral (2-view film study of each breast)*. Modifier 33 is not required because 77057 is a designated screening service. To report the same service for a Medicare patient, report G0202. Modifier 33 is neither required nor accepted by Medicare.

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

Rita Von Holtum, CPC-H, lead coder at Sanford Health, has been working in health care for 33 years. Working for a smaller facility, she has worn many hats including coding ED, outpatient, ambulatory surgery, and inpatient accounts. In 2001, she became a certified coder with AAPC. Rita is on the facility Compliance Committee, where her departments work with the Corporate Compliance department on changes and concerns. She mentors new and fellow coders.

By Richard Skaff

Improve Compliance in Behavioral Health

Better Documentation + Better Compliance = Better Quality of Care

Takeaways:

- Documentation is the key to compliance in reporting behavioral health.
- An accurate chargemaster is a significant component to proper behavioral health reporting.
- Compliance efforts are found to improve behavioral care.

Behavioral health has struggled with regulatory compliance, including documentation, billing and coding, treatment plans, and medical necessity. A "top down" approach to address shortcomings in behavioral health practice and diagnostics is the ultimate solution, but common sense and improved documentation will go a long way toward meeting compliance goals.

Document for Success

Documentation is an important aspect of compliance. To improve documentation, consider the following recommendations, courtesy of Anne Fisk and Mary Beth Thomas ("Regulatory Compliance Issues in Behavioral Health," *Journal for Healthcare Quality*, 2003; (133))

- A chart entry must describe the service, as well as justify it.
- The progress note documentation must be legible, and must include:
  - The date and duration of the session
  - A description of the nature of the treatment service
  - The patient's response to the therapeutic intervention
  - A plan
- Progress notes should contain recommendations for revisions in the treatment plan and an assessment of the patient's response to treatment and progress in meeting the goals set forth in the original treatment plan.
- The medical record must specify the psychiatric components of the record.
- The content requirements for admission documentation are spelled out, as are the expectations for the treatment plan and progress notes.

To improve coding and billing in behavioral health, Fisk and Thomas further recommend:

- An accurate charge description master (CDM or chargemaster)
- Access only to appropriate codes for the level of the provider (e.g., codes for evaluation and management (E/M) are not provided to practitioners who are not qualified to use them)
- Clinical documentation must justify the code billed, including medical necessity
- Edits to ensure only payer-qualified clinicians are providing the services billed
- Accurate diagnoses recorded on claims
- An efficient process flow, from the service rendered to the bill submitted for payment
- Formal, regular communication and feedback loops between billing and clinical areas
- Education for billers that improves their ability to discriminate among clinical services and for clinicians that underscores the critical nature of their documentation and coding choices

Compliance Improves Care

Regulatory compliance is entangled with quality of care. To help behavior health providers merge the two, Fisk and Thomas recommend these best practices:

- Investigate and implement evidence-based practices wherever possible and reasonable.
- Abandon the notion that behavioral health should be perceived as "different."
- Learn how other clinical areas in the system are handling compliance and share ideas.
- Recognize that treatment plans are helpful: Use them to direct treatment and to demonstrate that treatment's efficacy. Begin with accurate, precise diagnostics and a clear description of symptoms and presenting problems. Include behavioral goals that are concrete, realistic, measurable, and meaningful to the patient. Make sure the plan is individualized to the patient, and update the treatment plan whenever a change is reasonable or the current treatment has not proven to be effective.
- Use electronic health records (EHRs).
- Educate everyone—including billing, clinical, and management staff—about regulations, payer expectations, compliance, and quality.
- Perform internal quality audits.
- Spread the word that compliance is not optional.

In an increasingly regulatory world, ethics and compliance are no longer optional. Ethics must be emphasized and prioritized over billing. A diagnosis should never be made just for billing purposes.

Compliance issues must be taken seriously as a means for self-improvement and progress. Fear of punishment and penalties should not be the main incentive to implement an effective compliance program.

The strategic components that would deter or reduce a prospective compliance conflict in behavioral health would entail:

- Establishing an honest relationship with payers
- Implementing prevention and detection strategies
- Admitting mistakes and implementing self-correction, education, and ongoing training for employees, as well as risk management, and transparency

Richard Skaff is former CEO of K&M Consulting Services. He is a practicing clinical psychologist and is board certified in psychopharmacology and forensic psychology.

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By Pam Brooks, CPC

Consistency Calls for a Coding Policy Manual

With so many different interpretations to coding rules, your practice can't afford not to create one.

If coding were described as a color, it would be gray. Even with CPT®, ICD-9-CM, and HCPCS Level II guidelines, and despite regulatory guidance from the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), and commercial payers, many coding rules and concepts remain open to interpretation—especially with regard to evaluation and management (E/M) coding. How can coders (particularly those working in teams) apply their interpretations consistently? The solution is a coding policy manual.

Consistency Matters

The OIG recommends each practice and facility set up a compliance plan, and part of that compliance plan should include policies regarding correct and compliant coding. Consistent billing and coding is expected across the board so patients aren't billed differently for the same services no matter who codes the record. And uniform coding is crucial to ensure fair and reasonable physician compensation in practices and facilities where employed physicians are compensated based on volume or complexity of work—such as through a relative value unit (RVU)-based system.

photo by iStockphoto/Alexander Chaikin

In developing a coding manual, all coding rules and guidelines that currently have specific regulatory guidance should be followed. By prefacing your coding manual with verbiage such as, "It is the policy of XYZ Physician Practice that all professional fee services are coded and billed according to all current published Medicare, Medicaid, and third-party payer rules and guidance, including National Correct Coding Initiative (NCCI) edits and established documentation guidelines," you have set the standard and expectation for all coding concepts falling under published guidelines to be followed.

The bigger challenge is determining which coding concepts are ambiguous, coming up with a reasonable directive for your staff to clarify that uncertainty, and applying a policy across the board.

For example: The NHIC (Medicare administrative contractor for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) Evaluation and Management Coding Worksheet (form TMP-MDR-1013, July 2010) lists "drug therapy requiring intensive monitoring for toxicity" as a consideration for high patient risk. But neither the 1995 nor 1997 Documentation Guidelines for Evaluation and Management Services explain which drugs have the potential for toxicity, what frequency would constitute "intensive monitoring," or how that monitoring would occur. The worksheet stands alone without further clarification, potentially causing uncertainty and inconsistency in the coder's ability to determine the appropriate levels of service for E/M visits.

This scenario would translate well into practice-specific coding guidance to be used as a standard in a policy manual. With input from an existing practice policy (a list of high-risk medications that should be considered), as well as guidance from clinical staff (who determined the frequency established for 'intensive' monitoring), this scenario can be clarified to assist coders with determining the appropriate level of medical decision-making (MDM).

Create a Guidance Template

When creating a policy manual, a standard format is recommended. This allows for the consistent inclusion of required information, as well as guidance for creating future policies. A template—as shown in the example on the next page—will help assist the coder to capture all of the details and supporting documentation to be included in a practice-specific policy manual.

Template Example: Coding Guidance

XYZ Physician Practice
1234 Union Drive
Portland, ME 04103

CODING GUIDANCE:

High-risk Medications

Coding staff will determine high-risk MDM based on the E/M guidelines. Documentation should support patient risk.

GUIDANCE:

E/M auditing tools indicate that an element of MDM involving high risk can be determined if the patient is being intensively monitored for toxicity while undergoing drug therapy. Many high-risk medications require this kind of intensive monitoring. The XYZ Physicians Medication Policy MP-14.2.3 lists those medications that are high risk. They are: heparin, hypertonic NaCl, furosemide, insulin, Coumadin®/warfarin, and chemotherapy. Other medications may include Dilantin®, Synthroid®, mexotrexate (MTX) leflunomide (Arava®), sulfasalazine (Azulfidine), hydroxychloriquine (Plaquenil), etanercept (Enbrel®), infliximab (Remicade®), adalimumab (Humira®), abatacept (Orencia®), rituximab (Rituxan®), azathioprine (Imuran), mycophenolate (CellCept®), intravenous immunoglobin.

STANDARDS:

High risk in MDM can be determined when a patient is receiving drug therapy that could be potentially toxic without initiating intensive drug monitoring to assure appropriate therapeutic levels. Although XYZ Physicians Medication Policy MP-14.2.3 lists medications that are "high risk," treatment with these medications does not absolutely constitute high risk within the calculation of MDM unless the provider engages in intensive monitoring via serum levels.

Intensive monitoring is not defined; it is generally accepted by the XYZ physicians that serum levels examined no less than weekly would be considered "intensive." Coding staff should consult a clinician for further clarification, if necessary. Documentation must support that serum blood levels having been obtained within that frequency.

Other medications not listed in MP-14.2.3 may be considered if the patient undergoes intensive monitoring for toxicity.

RESPONSIBILITIES:

Professional coding staff, all XYZ employed physicians

REFERENCES:

NHIC Evaluation & Management Coding Worksheet, Document # TMP-MDR-0103, 07/06/2010, XYZ Physician Policy MP-14.2.3

For the most effective manual, organize your policies in a way that identifies the type and content of the guidance.

Under GUIDANCE, explain the rationale for the policy clarification, and under STANDARDS document any relevant regulatory guidance you've identified that will support your new policy. RESPONSIBILITIES will list the employees who are expected to recognize and follow the policy. Under REFERENCES, you can list web-based links, internal hyperlinks, or other references such as existing policies that support your new policy.

Document your policies on practice letterhead, and name the policy with a title that will help you search and identify it later. Remember to date the original policy, and indicate any subsequent updates.

Organize for Easy Reference

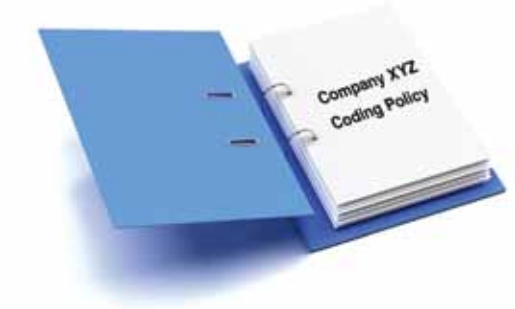
Storing your policies in a way that you can easily find, view, and reference them can be a challenge. An ideal location is a shared computer network drive that is accessible by all employees. Make sure the final policy documents are protected against inadvertent additions or changes by making the files "read only" for all staff except the administrators. You can also reformat your documents into a read-only PDF file.

A paper copy in notebook format is an alternative for small practices where a shared drive is not an option—and it's readily available in case of a computer system failure. You also could maintain one e-copy of the manual on a dedicated computer, or have each staff member keep an updated and organized manual on his or her individual desktop or hard drive.

For the most effective manual, organize your policies in a way that identifies the type and content of the guidance. For example:

- File your policies by topic, such as E/M, surgical specialties, and modifier usage.
- Create files for specific payers, such as CMS guidance and Anthem guidance.
- Create a dedicated file for office and reporting procedures specific to the billing or coding staff, such as how to run certain reports and how to set up accounts.

Having these administrative procedures in a single location can also serve as a great training and reference tool. Keeping an updated table of contents allows you to view the separate policies in each folder, but you can also use your software's search feature to identify policies related to a specific key word. That's why it's important to clearly name your policies in ways that can identify the content.



Get Everyone Involved

Although coding managers typically draft and finalize the coding procedures in their practice or departments, staff coders should use their specific areas of expertise to assist in the research and recommendations of practice- and specialty-specific coding guidance. Their day-to-day coding challenges and scenarios that have no clear-cut answers are crucial and need to be part of the coding policy manual.

When problem areas are identified, research published guidelines to find existing regulatory guidance. If no specific guidance is found, or if the guidance is ambiguous, work together to find a reasonable solution and to create specific coding guidance. Sometimes it's helpful to visit an out-of-area contractor website for direction, particularly if your own contractor's guidance is less detailed. At the very least, you can devise more specific guidance that can be followed until your local contractor provides clarification.

Other resources include hospital or practice policy, individual payer guidelines, and guidance from professional medical associations. When your policy is in draft format, make sure it does not conflict with other regulatory guidance or existing policy. You may need to only update a current policy, rather than write a new one.

Update Often

Each year, particularly when updates occur, your procedures manual should be reviewed to determine whether changes are necessary based on more detailed regulatory guidance, new technology, etc. Occasionally, with clarification of regulatory guidance, older policies can be eliminated.

For example, prior to 2011 there was limited guidance about how to code and bill for physician observation services if the patient remained in observation longer than 48 hours. A coding policy manual prior to 2011 may have outlined the use of CPT® codes 99211-99215 for these services. With the introduction of codes 99224-99226, however, the earlier policy would need to be eliminated.

When making changes or revisions, provide a revision date and make a brief notation as to why the policy was changed. This eliminates those, "We used to do it this way, but why?" moments.

A clear and accessible coding policy manual can also assist with staff development, training, and evaluation. All coding staff should be aware of and have access to, the policy manual. Use of the manual and its guidelines should be standard for all coders; have this expectation stated in the coder's

job description. If a coder deliberately fails to follow a written policy, the manual acts as supporting documentation if progressive discipline is necessary. Should providers or administration question the methodology of the coding process for any reason, the coding policy and its references to related regulatory guidance can also help validate and support the actions of the coding staff.

A common joke heard in the health care industry is, "Coders are like lawyers. Ask two of them the same question, and you'll get two different answers." Until regulatory coding guidance addresses all of those gray areas of coding, a policy manual will go a long way to provide consistent coding and clarifications of practice processes.

Pam Brooks, CPC, is physician services coding supervisor at Wentworth-Douglass Hospital in Dover, N.H., where she oversees a professional-fee coding department supporting 28 practices and outpatient departments with over 100 providers. She holds a Bachelor of Science in Adult Education and Workplace Training from Granite State College, and is currently working on her master's in Health Administration at St. Joseph's College of Maine. She is a past secretary of the Seacoast-Dover, N.H., AAPC Local Chapter.

Takeaways:

- Because so much of coding falls into gray areas, consider developing a coding manual for your office to assure consistency and compliance.
- Involve everyone in the office and develop a mechanism to keep it updated.
- Consider putting the manual online for easy access.

A&P Quiz

Correct answer is d: Insulin is a hormone produced by special cells called beta cells in the pancreas. The pancreas is found behind your stomach. Insulin is needed to move blood sugar (glucose) into cells, where it is stored and later used for energy. In type 1 diabetes, beta cells produce little or no insulin. Without enough insulin, glucose builds up in the bloodstream instead of going into the cells. The body is unable to use this glucose for energy. This leads to the symptoms of type 1 diabetes.
Source: NIH

By Ida Landry, CPC

E-commerce Provides Patient Ownership in Health Care

With health information available online, the patient/provider relationship is changing.

The Internet and telephone have become increasingly popular methods for providing medical assistance and enhancing patients' health care experience. Combined with supplementing face-to-face office visits, these alternative services offer a quality of care not seen since the days of the house call.

Revised Coding Paved the Way

Recent coding revisions help pave the way for greater acceptance of telephone and Internet-based health services.

Telephone service codes 99371-99373 were deleted in the 2009 CPT® codebook. These codes held no relative value units (RVUs), and were not paid by any insurance company. Tracking and trending purposes were the only reason for coding these services. Mostly because these codes held no monetary value, the health care community saw no reason to use them. To replace 99371-99373, CPT® introduced new telephone services codes 98966-98968 (for use by nonphysician providers) and 99441-99443 (for physicians).

Also added in 2009 were online patient service codes: 98969 for nonphysician health care providers and 99444 for physicians.

Services appropriately provided and reported with the new codes now had a dollar value, which prompted providers to respond by offering telephone and Internet services more broadly. No longer was health care restricted to face-to-face visits. Clinics such as Texas' Internet Medical Clinics are on the forefront of health care and are paving the way for alternative medical services through the use of the Internet.

Change in Patient's Health Care Habits

The term "e-patient" describes patients who are using the Internet to find or receive health care information or services. With the Internet comes the ability to research health information online, which has changed the patient/provider relationship. For example, e-patients often have a more comprehensive understanding of chronic conditions upon seeing a health care professional.

Research has tried to identify who e-patients are. In "The Social Life of Health Information," (www.pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information.aspx) authors Susannah Fox and Sydney Jones state (on page 8), "83 percent of internet users, or 61 percent of U.S. adults, have looked online for information … ranging from information about a specific disease, a certain treatment, alternative medicine, health insurance, doctors, hospitals, and ways to stay healthy." These same individuals are learning there are new ways to get health care services without stepping foot in their doctor's office or a hospital. Places like the Internet Medical Clinics offer services online 24 hours a day, seven days a week. An established patient can get urgent prescriptions and take care of basic health care needs without leaving his or her home, and providers can now receive payment from health insurance companies for these health care services.

Online Care Offers a Win/Win

The Internet has taken health care to a new level when it comes to helping patients stay healthy. "E-patients" have started to take ownership of their ailments. Federal legislation, such as the Health Information Technology for Economic and Clinic Health (HITECH) Act of 2009, has set guidelines for health care regarding e-commerce and protection of patient health information. The creation of new codes and payment of those codes has opened up new avenues of patient care.

Although still at its infancy, e-commerce and health care offers a positive relationship that could benefit everyone. As more clinics like Internet Medical Clinic find financial and patient health benefits through e-commerce, this trend will become mainstream.

Ida Landry, CPC, has worked in health care since 1995, and acquired CPC® certification in 2004. Ida holds a Bachelor of Science in Health Administration and is working on her Master of Business Administration (MBA), with a focus on health care management. She enjoys teaching and sharing her knowledge of coding.

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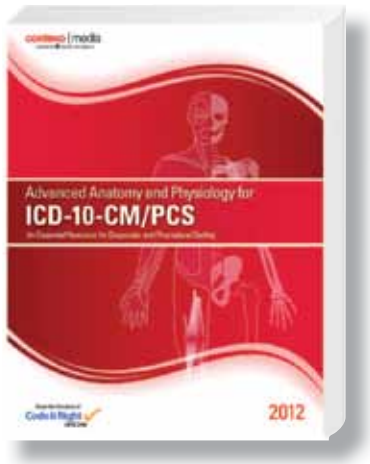

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By Dorothy Steed, CPA, CPC-H, CPC-I, CEMC, CFPC, CPMA, CHCC, CPUM, CPUR, CPHM, CCS-P, ACS-OP, RCC, RMC

Chargemaster: Learn an Integral Component of Facility Billing and Coding

With a trend moving toward hospital care, consider chargemaster basics.

As more physicians head under the hospital umbrella to furnish cost-effective care, opportunities are opening for coders in the facility environment. Your doctor may be considering a move to a facility setting, or perhaps you've been considering taking advantage of new emerging hospital jobs. Whatever your motivation may be, now is a good time to learn as much as you can about the nuances of facility coding. To get you better acquainted with hospital coding and billing, let's talk about one area of coding that is different from the physician office: the chargemaster.

The chargemaster is a large master file combining all services provided by each hospital. As patients receive services, that department enters the charges through this mechanism.

The structure contains these elements:

- An internal general ledger number
- A revenue code under which the charge will be posted
- A CPT® code
- The facility's charge for one unit of service

Also included is a flag which indicates a current service, service or code scheduled for deletion, or inactive service.

Chargemaster Maintenance

The chargemaster needs to be updated at least annually, and when beginning new services or discontinuing current services. This task is likely to be a full-time position in a large facility. When a new fiscal year begins, it is common for hospitals to increase their rates across the board. This requires chargemaster updating to reflect the new rates. Chargemasters also must be updated to reflect ongoing code changes.

Posting Charges

Typically, all laboratory, radiology, respiratory/pulmonary, and therapy services are posted from the chargemaster, as well as pharmacy and supply charges. If the facility has a dedicated gastrointestinal (GI) or cardiovascular lab, these charges may also be posted through the chargemaster. When the designated department provides services to a patient, the department is responsible for entering the correct charges to the patient's financial record. For admitted inpatients, the unit on which the patient is admitted will post the applicable room charges, drugs, and supplies to the patient record. Clinics, the emergency department, and the observation area will post facility charges applicable to their respective areas; and surgery, anesthesia, and recovery will post their charges. For surgery, anesthesia, and recovery, 1 unit typically equals 15 minutes (4 units would equal 1 hour).

Takeaways:

- As more physicians move to hospital employment, it's wise to learn the chargemaster.
- The chargemaster allows facilities to document and charge for outpatient services.
- Coders and billers have key roles in making the chargemaster succeed.

It is customary for facilities to set their financial systems to drop claims to the biller's queue in a specific number of days after patient encounter. For example: If it is set for six days, the claim will drop to the biller on day seven. This step allows time for departments to complete charging for their patients and for the coding department to finalize coding.

Coder's Role

Facility coders are responsible for diagnosis coding of all inpatient records, ambulatory surgery, emergency department, and ancillary service departments. It isn't uncommon to report 15 or more diagnosis codes on an inpatient record. Coders apply CPT® codes for ambulatory surgery and some emergency services. Patients who present for diagnostic testing, such as laboratory or radiology, will not require CPT® codes from the coding staff because these codes will be applied by the chargemaster. CPT® codes are not reported on inpatient claims; however, procedure codes from ICD-9, volume 3, must be applied by the coder. Facility coders also are required to report the present on admission (POA) indicator on inpatient claims and abstract the record. The abstractor is a separate software program that finalizes the coding function. These steps must be completed based on productivity and accuracy standards.

It is not uncommon to report 15 or more diagnosis codes on an inpatient record.

Biller's Role

Billers and coders generally are maintained as separate departments in a facility, and likely do not interact with each other on a daily bases. The coders may be stationed in the health information management department, or they may be working remotely from home. Billers are most commonly based in the business office.

Once a claim drops to the biller's queue, the responsibility then falls to the biller to review the claim information for posting errors, missing charges, missing modifiers, incorrect number of units, and coding completion. The facility biller must be adequately skilled to make these determinations. Although it is unlikely that each drug or supply will be recognized by the biller, he or she must be able to determine when required charges are missing. Examples are:

(1) Anesthesia and recovery is charged; no surgery charge

(2) Procedure code indicates implant; charge for implant is missing

(3) 230 units charged for anesthesia (This would equate to 15 hours under sedation, an unlikely number of units.)

If the biller determines that a claim has erroneous or missing charges, he or she must place a hold on the claim until the errors have been corrected. One rationale for the facility financial system's automatic dropping of claims is to maintain some control of unbilled claims. The billing manager can determine the number of claims dropped to each biller and the number of claims released by the biller. The biller is held accountable for claims assigned to his or her queue, and must be ready to report held claims due to charge errors or incomplete coding. If certain departments have a high incident of incorrect or delayed charging, the manager of that department is likely notified and expected to develop an action plan to reduce charge posting errors. If there is a coding backlog, coding management is expected to explain the delay and provide a reasonable plan to bring the work current.

Delays and Late Charges

Another potential problem is charge posting delays over a three-day holiday. If services rendered on Friday are not posted until sometime the following week, the original claim will be incomplete. The delayed posting will drop to the biller queue as late charges (depending on how many days the financial system is set for dropping the claim). Medicare typically pays hospitals based on Medicare Severity Diagnosis-related Group (MS-DRG) for inpatient claims and Ambulatory Payment Classifications (APC) for most outpatient services. This equates to reimbursement for all services based upon the calculation; late charge billing is not accepted from facilities that are reimbursed based on these concepts. This is another reason facility billers must be skilled enough to recognize missing charges. If deemed to be the case, the claim must be held until the late charges have dropped and those charges must be added to the original claim. If released prior to the late charge inclusion, the original claim must be revised and resubmitted as an adjusted claim.

Keeping Errors in Check

The skill set required for facility billers is much different from physician billers. Although the chargemaster is a valuable tool used for charge maintenance and posting, the users must exercise care in correct posting and the biller must keep billing errors to a minimum. These performance stats are often tracked by management to determine areas of billing weakness and to plan for and implement training where deficiencies are identified.

Planning Ahead for Hospital Coding Trends

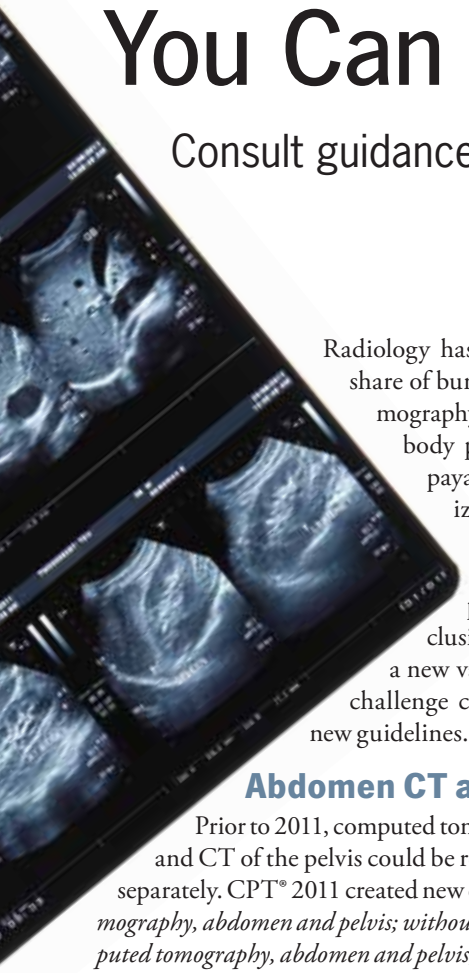
The Certified Professional Coder-Hospital Outpatient (CPC-H®) credential prepares a coder for the specialized payment knowledge necessary for facility jobs. The CPC-H® credential recognizes expertise in the area of outpatient hospital, hospital-based ASC coding, and independent ambulatory surgery centers (ASC). If you are interested in solidifying your expertise in these areas, go to www.aapc.com/certification/cpc-h.aspx to learn more.

Dorothy Steed, CPA, CPC-H, CPC-I, CEMC, CFPC, CPMA, CHCC, CPUM, CPUR, CPHM, CCS-P, ACS-OP, RCC, RMC is a technical college instructor in Atlanta and an independent consultant, performing physician audits and education for the Quality Improvement Organization in Georgia. Her 34 years of experience in health care includes working as a Medicare specialist for a large hospital system, as well as contributing to various medical publications, presenting at health care conferences, and developing training classes focusing on facility billing, coding, and reimbursement.

By Lori M. Shore, CPC, RCC

Bundling Rules You Can Take to the Radiologist

Consult guidance when coding these studies to ensure proper reporting.



Radiology has arguably had more than its share of bundling recently. Computed tomography (CT) scans of certain separate body parts are no longer separately payable; endovascular revascularization studies are now grouped into all-inclusive territories; and several renal angiography procedures are now all-inclusive, as well. These changes put a new value on radiology services and challenge coders and clinicians to learn new guidelines. Allow me to explain further.

Abdomen CT and Pelvis CT

Prior to 2011, computed tomography (CT) of the abdomen and CT of the pelvis could be reported, and were reimbursed, separately. CPT® 2011 created new codes (e.g., 74174 *Computed tomography, abdomen and pelvis; without contrast material*, 74177 *Computed tomography, abdomen and pelvis; with contrast*, and 74178 *Computed tomography, abdomen and pelvis; without contrast material in 1 or both body regions, followed by contrast material(s) and further sections in 1 or both body regions)* that bundle the procedures when performed together.

Such bundling has a significant financial impact. For example, per the 2012 Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Relative Value File, CT of the abdomen with contrast (74160 *Computed tomography, abdomen; with contrast material(s)*) is valued at 1.27 work relative value units (RVUs), while CT of the pelvis with contrast (72193 *Computed tomography, pelvis; with contrast material(s)*) is 1.16 RVUs. If reported separately, these codes total 2.43 RVUs. But when these procedures are bundled into the single code 74177 (as they have been since Jan. 1, 2011), the work RVUs are 1.82, or approximately 25 percent lower.

Takeaways:

- Recent changes have bundled several services into radiology codes.
- New guidelines and reimbursement challenge coders to report accurately.
- These changes impact CT, CTA, endovascular revascularization studies, renal angiography, and AV shunts for dialysis.

Abdomen CTA and Pelvis CTA

Similarly, CPT® 2012 created a single code (74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing*) to bundle CT angiogram (CTA) of the abdomen and of the pelvis. Previously, these procedures were coded independently of one another. As of Jan. 1, 2012, it is no longer appropriate to report these studies separately when they are performed at the same time; you must use the combined code (74174).

Endovascular Revascularization Studies

Endovascular revascularization studies (37220-37235), often done percutaneously by interventional radiologists, were bundled into all-inclusive territories with a hierarchal system in 2011. Any revascularization procedures done in the common, internal, or external iliac arteries are now considered iliac territory. The anterior tibial, posterior tibial, and peroneal are now considered tibial-peroneal territory, and any vessel in the femoral-popliteal system is considered part of that territory. Therapeutic interventions are now inclusive of the higher valued "level." Angioplasty is the lowest valued intervention, followed by atherectomy (which is also included in the highest level, which includes stent(s) placement). Conscious sedation is also included in these bundles.

Note: For more information about bundling of interventional vascular studies, see "Master the Significant Revisions to 2011 Vascular Codes," February 2011 *Coding Edge*, pages 34-37.

Renal Angiography

In 2012, renal angiography is bundled for both selective (36251-36252) and superselective (36253-36254) catheter placements; conscious sedation is included in these all-inclusive bundles. Intravascular vena cava (IVC) filter codes are also bundled this year into all-inclusive codes for insertion (37191), repositioning (37192), and retrieval (37193):

37191 Insertion of intravascular vena cava filter, endovascular approach in-

Although not an outright code change or bundle, there is a lengthy narrative clarification in CPT® 2012 regarding arteriovenous (AV) shunts for dialysis.

cluding vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

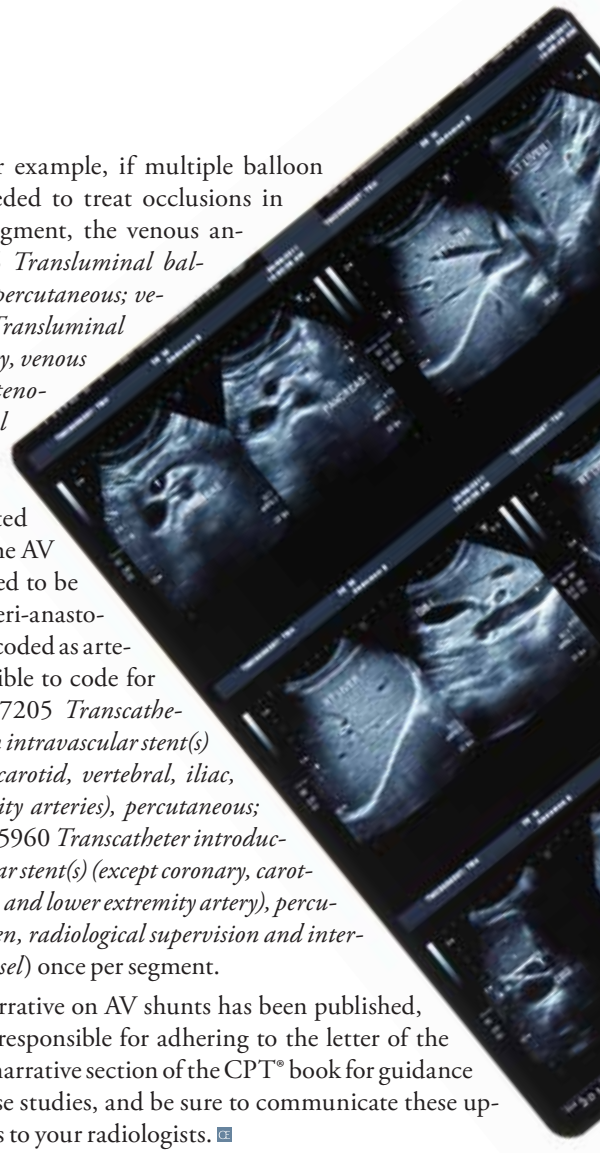
37192 Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

AV Shunts for Dialysis

Although not an outright code change or bundle, there is a lengthy narrative clarification in CPT® 2012 regarding arteriovenous (AV) shunts for dialysis. The narrative defines the AV shunt as beginning with the arterial anastomosis and extending to the right atrium. All catheter manipulations for diagnostic imaging are included in 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava).* If ultrasound guidance is properly documented, +76937 *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)* may be separately reportable. Additional work needed in the peri-anastomotic segment, defined as the short segment of artery immediately adjacent to and distal to the anastomosis, and the anastomosis itself, is also separately reportable.

Interventions performed within the AV shunt are divided into two vessel segments for coding purposes. The peripheral segment is defined as the peri-arterial anastomosis through the axillary vein. The central segment is defined as including the subclavian and innominate veins through the vena cava. Any intervention in either segment, regardless of the number of lesions treated, is coded as one intervention. For example, if multiple balloon catheters are needed to treat occlusions in the peripheral segment, the venous angioplasty (35476 *Transluminal balloon angioplasty, percutaneous; venous* and 75978 *Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation*) would be reported one time only. The AV shunt is considered to be venous, and the peri-anastomotic segment is coded as arterial. It is permissible to code for stenting work (37205 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel* and 75960 *Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel*) once per segment.



Now that this narrative on AV shunts has been published, we as coders are responsible for adhering to the letter of the law. Consult the narrative section of the CPT® book for guidance when coding these studies, and be sure to communicate these updates and changes to your radiologists.

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By Stacy Harper, JD, MHSA, CPC

E/M Benchmarking:

Strategies to Minimize Your Audit Risk

Understand your use of CPT® codes prone to audit review.

In the current regulatory environment, physicians are searching for ways to minimize audit exposure. Medicare administrative contractors (MACs) frequently review high-level evaluation and management (E/M) services. Review may be based on a random sample, or targeted based on provider usage. In either case, providers with high targeted code use are more likely to be audited.

The 2012 Office of Inspector General (OIG) Work Plan also includes scrutiny of providers with high cumulative Medicare Part B payments, trends in coding of E/M services, and potentially inappropriate E/M payments (see HHS OIG Work Plan FY 2012, Part I: Medicare Part A and Part B, Other Providers and Suppliers at http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP01-Mcare_A+B.pdf).

All Medicare contractors participate in pre- and post-payment review of E/M documentation. Some publish targeted service areas. For example, WPS® Medicare currently plans pre-payment reviews of 99223, 99203, 99233, 99232, and 99215. Palmetto GBA® has plans for pre-payment review of 99214 and Trailblazer® reports it has edits in place for all E/M service codes.

To minimize the risk of an audit, providers must be aware of and understand their utilization of CPT® codes prone to audit review. Some payers are assisting with this awareness by notifying providers with high usage of targeted E/M codes. Providers should not assume, however, that their use of each level of service is in line with usage benchmarks for their specialty just because they have not received such letters.

E/M Coding Benchmarks

The first step in determining a provider's audit risk is to compare his or her utilization of E/M codes against other physicians' in his or her specialty. The Centers for Medicare & Medicaid Services (CMS) publishes Medicare Part B utilization data each year (available at www.cms.gov/MedicareFeeforSvcPartsAB/04_MedicareUtilizationforPartB.asp). The most recent data available is based on claims paid in 2010, which covers the use of all E/M codes by provider specialty. Providers can calculate benchmarks, or bell curves, for E/M service usage in their specialty by comparing the number of allowed services for each CPT® code as a percent of the total allowed services for a given E/M subcategory billed by providers in the same specialty.

Usage percentages for the six highest volume Medicare specialties for new patient office visits, established office visits, inpatient admissions, and subsequent hospital visits, based on 2010 utilization data, are shown in **Graphs A-D** on the next page. Because the available data is for Medicare claims, it will be less accurate for specialties with low Medicare volumes. More accurate data may be available from professional specialty organizations for these providers.

When the benchmark or bell curve for a specialty has been determined, a physician's claims for E/M services can be compared to identify deviations from benchmarks.

Service Volume

In addition to the distribution of the types of services a physician is billing, the overall volume of services may affect his or her risk of an audit. Providers can compare their total annual revenue to standards for their specialty. The Medical Group Management Association (MGMA) and other professional organizations gather physician revenue data and publish reports showing revenue by specialty. These reports show revenue for the 25th, 50th, 75th, and 90th percentiles. Providers with revenue in the higher percentiles are more prone to auditing.

Analysis of Your Physicians

Although usage may be outside of revenue and level-of-service averages for a specialty, services may still be appropriately coded. Deviations in utilization may be based on variations in patient mix, subspecialization, marketed service areas, or increased productivity; however, high usage can also be related to improper coding, inflated documentation, and false claims.

For example, with the implementation of electronic health records (EHRs), physicians are now able to easily document more information for each visit. Electronic note configuration settings may cause the system to pull information into a note that is not relevant to the presenting problems or the provider's treatment decision.

This shift in physician documentation patterns frequently correlates with a shift in the physician's billing practices. When reviewing high-level E/M services, it is important to consider more than just the quantity of the documentation. Per the Medicare *Claims Processing Manual*, pub. 100-04, chapter 12, section 30.6, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be med-

Providers with revenue in the higher percentiles are more prone to auditing.

ically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."

To ensure billing and coding compliance you must understand the accuracy of physician coding. An effective auditing program is central to every corporate compliance plan (see OIG Compliance Program for Individual and Small Group Physician Practices, 65 FR 59434). You can minimize risk and improve compliance by aligning your auditing program to reflect the auditing programs of major payers. For E/M services, this means focusing your reviews on any high-level codes where the physician's usage is above the "bell curve."

Resolution and Compliance Improvement

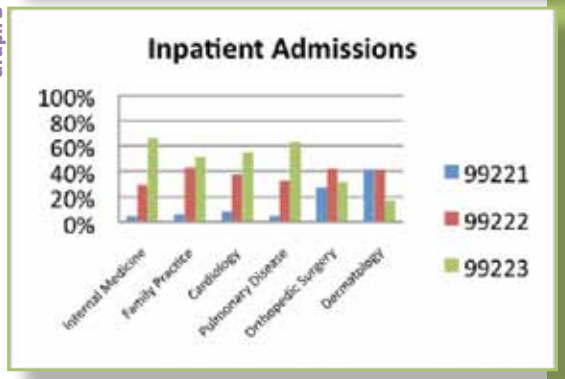
Although the goal of any audit is to confirm compliance and justify any deviation from expected use, audits also frequently identify billing and coding errors. Any incorrectly coded services resulting in an overpayment to the physician must be corrected, and payment refunded to Medicare within 60 days of identification (see OIG Compliance Program for Individual and Small Group Physician Practices, 65 FR 59434). If a high error rate is discovered, a pattern of inaccurate coding may exist and additional auditing may be warranted.

In addition to correcting identified errors, auditing can be used as a foundation to educate providers and improve coding accuracy. Even when a physician's coding is accurate, if high usage places him or her at increased risk for auditing, documentation improvement can be critical. When EHRs are used, review template settings to align the quantity of documentation with the nature of the presenting problem to improve coding accuracy and realign the provider's usage with benchmarks.

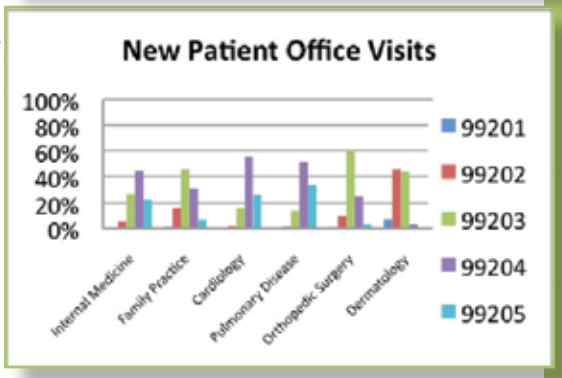
Auditing of records by third-party payers is a reality in the current health care system. Medicare and other payers track where your providers fall in the spectrum of service use. Knowing your provider's utilization, understanding the related level of risk, and identifying problem areas in his or her E/M coding is your best strategy to minimize the impact of external audits to your practice.

Graph A

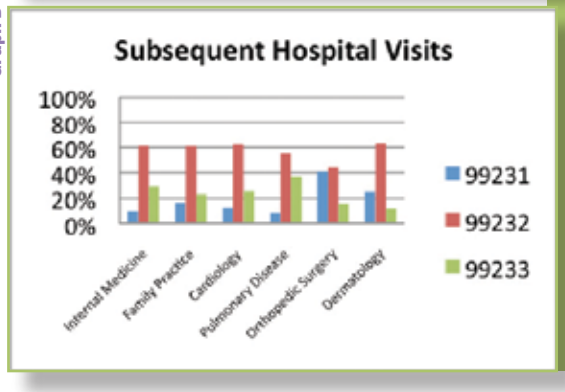
Graph B



Graph C



Graph D



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Michelle Lusby, **CPC-A**
Michelle Lynn Brown, **CPC-A**
Michelle Noguera, **CPC-A**
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Nancy B. Cowen, **CPC-A**
Nancy Chaney, **CPC-A**
Nancy Fackler, **CPC-A**
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Nayle Durruthy, **CPC-A**
Ngan Ly, **CPC-A**
Nicole Denison, **CPC-A**
Niki Witmer, **CPC-A**
Njmah Beyah, **CPC-A**
Noelle Strommen, **CPC-H-A**
Nora Busby, **CPC-A**
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Pamela Jones, **CPC-A**
Pamela Kaye Palmer, **CPC-A**
Patrice Alton, **CPC-A**
Patricia Callahan, **CPC-A**
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Patrick Ryan Jonas, **CPC-A**
Patti Krebs, **CPC-A**
Paula Johnson, **CPC-A**
Penny Bailey, **CPC-A**
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Quintisa Mcdonald, **CPC-A**
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Rebecca Lynne Moore, **CPC-A**
Rebecca Oshell, **CPC-A**
Rebecca Watson, **CPC-A**
Regina Buck, **CPC-H-A**
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Rita Kipp, **CPC-A**
Robyn Marie Rutto, **CPC-A**
Ronda Osborne, **CPC-A**
Rosanne L Jacob, **CPC-A**
Rosario C Garcia, **CPC-A**
Roxanne L Jarvis, **CPC-A**
Roxanne L Jarvis, **CPC-A**
Ruben Anthony Posada, **CPC-A**
Sandra Burton, **CPC-A**
Sandra Marie Vaupel, **CPC-A**
Sandra Marie Vaupel, **CPC-A**
Sandra Watson, **CPC-A**
Sara Frischer, **CPC-H-A**
Sarah Elizabeth Holloway, **CPC-A**
Sarah Frick, **CPC-A**
Sarah Fuller, **CPC-A**
Sarah Villalobos, **CPC-A**
Seirah W Carlyle, **CPC-A**
Shane Dayton, CPC-A, **CPC-H-A**
Shannon Coschia, **CPC-A**
Shannon Martin, **CPC-A**
Sharmela Holloway, **CPC-A**
Sharon Oesch, **CPC-A**
Sharon Joanne Kroetsch, **CPC-A**
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Susan Austin, **CPC-A**
Susan Dare, **CPC-A**
Susan Daust, **CPC-A**
Susan Lowrey, **CPC-A**
Sydney Huson, **CPC-A**
Syla Khim, **CPC-A**
Tammie Hoxsie, **CPC-A**
Tanny Siu, **CPC-A**
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Tiffany Tina Reyes, **CPC-A**
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Tom Wilhoite, **CPC-A**
Tonia Renee Smith-Fryson, **CPC-A**
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Toshia Katherine Stark, CPC-A, **CPC-H-A**
Trish Jones, **CPC-A**
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Windie Marie Thompson, **CPC-A**
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Yvonne Sukhai, **CPC-A**

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Amy Leona Yonce, **CEMC**
Beth Eve Schleeper, CPC, **CPCO**
Brittany Feckley, CPC, **CPCO**
Carmella Johnson, CPC, **CPMA**
Charlotte Neubauer, CPC-P, **CPMA**
Cheryl F Sherrill, CPC, **CGIC**
Christina J Musser, CPC, **CPCO**
Ciera Garvin, **CPCD**
Claire D Van Deinse, CPC, CGIC, **CGSC**
Corina Marquardt, CPC, **CPMA**
Cynthia Knutson, **CPCD**
Cynthia Knutson, **CPCD**
Danielle Mazzola, CPC, **CPMA**
Dawn Rene Smith, CPC, **CEDC**, CEMC
Debra T Shelton, CPC, **CEMC**
Donnamarie Williams, CPC, **CPMA**
Doris Di Bella, CPC, **CEMC**
Doris Vera, CPC-A, **CHONC**
Evan Gwilliam, CPC, **CCPC**
Gina Emmenegger, CPC, **CPMA**, CEMC
Gregory Quinn, **CHONC**
Heather Greene, **CPMA**
Helen Matas, CPC, **CIRCC**
Jaime M Fiore, **CRHC**
Janelle Foushee, **CPCD**
Jeannine Ramsey, **CEMC**
Jennifer Jobe, **COBGC**
Jessica Lynn Boes, CPC, CPMA, **CANPC**
Jody Sailors, CPC, CEMC, **CFPC**
Joselyn A Privratsky, CPC, **CEDC**
Joymesha Weatherall, CPC, **COBGC**
Juana Guerrero, **CPCD**
Julie Wilson, **COBGC**
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Kathleen Hurley, CPC-A, **CPMA**
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Lidia Fernandez, **CFPC**
Linda Loveless, **CGIC**
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Maria J Garcia, CPC, CPC-H, **CPMA**
Maria Oatman, CPC, **CEMC**
Marisol Hernandez Gomez, CPC, **CPCO**, CPMA
Melanie Marchant, **CPRC**
Melissa Davis, **CPCD**
Nelda Ortega, CPMA, **CCC**
Patricia Lynn Wright, CPC, **CPMA**
Rebecca Pendergraft, CPC-A, **CEMC**
Regina McGee, CPC, **CPMA**
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Romenza Kaye Thomas, CPC, **CPMA**, CEMC
Rosa D'Ascoli, CPC, **CPMA**
Sabrina King, **CEMC**
Sharon L VanAlstyne, CPC, **CPMA**
Sherri Keene, **CPMA**
Sherry Davis, CPC, **CPMA**, CPC-I
Shontia Norrell Leon-Guerrero, CPC, **CEMC**
Sidikat Oriowo, CPC, CPC-H, **CPMA**
Susan Sandgren, **CASCC**
Susan Edwards, CPC, **CEDC**
Tawanda Nadine Johnson, CPC, **CEDC**
Tesha A Richards, CPC, **CPMA**
Tiffany Fischer, CPC, **CEMC**
Tracy Wells, **CEDC**
Victoria Ortega, CPC, **CPMA**, CIMC
Wendy Kaschalk, **CANPC**
Yan Shao, **CIRCC**

Magna Cum Laude

Beth Strandell, **CPC-A**
Brenda Shaffer Grimes, **CPC**
Brianne Ferguson, **CPC-A**
Debbie Taube, **CPC-A**
Edward Neilsen, **CPC**
Jennifer Sanetta, **CPC**
Kim Morvant, **CPC-A**
Peggy S Miller, CPC, **CANPC**
Sandra Marie Vaupel, **CPC-A**
Seirah W Carlyle, **CPC-A**
Shane Dayton, CPC-A, **CPC-H-A**
Trisha Leavitt, CPC-A, CPMA, **CASCC**

ADD vs. ADHD continued from page 25

- Has symptoms that affect school, home life, or relationships in more than one setting (such as at home and at school)

A child diagnosed with ADHD is often given a more specific diagnosis, such as:

- **Predominantly inattentive-type ADHD**: a child has at least six signs and symptoms from the inattention list above.
- **Predominantly hyperactive-impulsive-type ADHD**: a child has at least six signs and symptoms from the hyperactivity and impulsivity list above.
- **Combined type ADHD**: a child has six or more signs and symptoms from each of the two lists above.

When assigning ICD-9-CM codes, report 314.00 *Attention deficit disorder without mention of hyperactivity* for ADD and 314.01 *Attention deficit disorder with hyperactivity* for ADHD.

As we move forward to ICD-10-CM, the coding is reflective of the specificity that the APA has required.

Examples include:

F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type

F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type

F90.2 Attention-deficit hyperactivity disorder, combined type

As a coder, the good news is the specificity of ICD-10 is coming. As the mother of a child with ADHD, the good news is that research shows approximately 93 percent of children diagnosed with ADD or ADHD can acquire coping skills to adjust without the use of medications in adulthood.

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

Debbie Flieger, CPC

Coding Manager, St. Anthony's Physician Organization

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

I started 20 years ago in health care as a registered medical assistant working in urgent care. I later went on to work as the clinical instructor in a medical assisting program. Company changes later required me to be flexible and add the responsibility of teaching front office skills, as well. My career path led me to a family practice office as the back office supervisor and later the front office, as well. Out of necessity, I began coding, entering charges, doing accounts receivable (A/R), etc., for the 10 years I was there.

I missed teaching and decided to teach a few evening classes. It was during this time that I was offered the opportunity to sit for the Certified Professional Coder (CPC®) exam, which I jumped on. After passing, I was offered a full-time lead instructor position where I was in charge of billing and coding, as well as the medical assisting programs. I enjoyed teaching for several years, and then accepted a position as reimbursement manager for a 16-provider, multi-specialty practice. Today, I am the coding manager for a 26-physician office, where I manage coders and provide education for both coders and physicians.

2. What is your involvement with your local AAPC chapter?

I am the president of the St. Louis West Missouri local chapter. I have served as member development officer and president-elect. I also have presented several anatomy, medical terminology, and ICD-10 documentation presentations for the chapter. I attended my first national conference this year. We also created a scholarship fund for our members and have raised over $7,000 from the anatomy classes. My goal is to provide members with quality, affordable continuing education unit (CEU) opportunities of $10 CEUs or less.

3. What AAPC benefits do you like the most?

Networking! Hands down, it's the best benefit.

4. What has been your biggest challenge as a coder?

My biggest challenge as a coder has been teaching coding. During any given day I could be teaching six to seven different specialties.

5. How is your organization preparing for ICD-10?

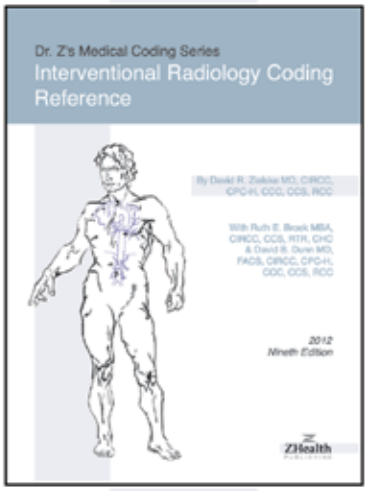
We have been training staff on anatomy and working on documentation issues with both the staff and providers.

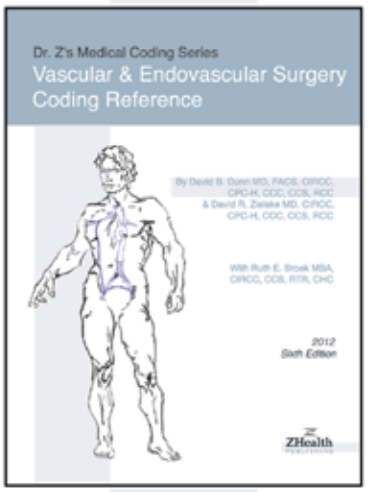
6. If you could do any other job, what would it be?

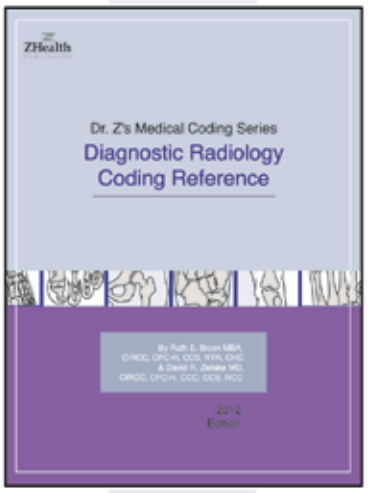
Travel coding or consulting ICD-10 project manager would be fun for a while, as well.

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

I spend my spare time with my family. I have a wonderful husband of 20 years and two great kids. My son is a freshman at Murray State so we make lots of trips to visit him. My 13-year-old daughter is a competitive dancer and a basketball player, so I spend a lot of time being a dance mom. I enjoy reading historical romance and Civil War novels. And last, but certainly not least, I am an avid Walt Disney World nut and am happiest when planning another trip to the most magical place on Earth. I am planning our next trip for this July; it's our fourth.







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