



June 2012

CODING edge

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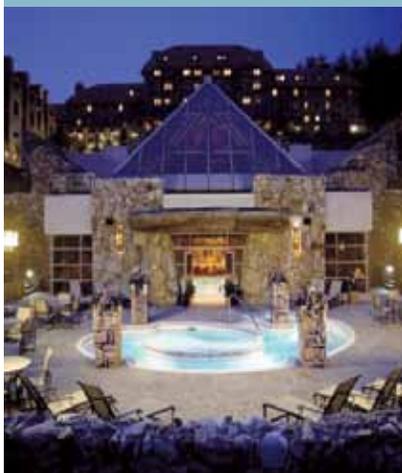


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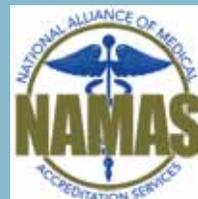
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On the Cover: 2011 Chapter of the Year, Springfield, Mo., stands at Jordan Valley Park with compassion and pride. Cover photo is by Inlight Studio/Deanna Sammons Photography (www.deannasammons.com).

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Chairman and CEO

Reed E. Pew
reed.e.pew@aapc.com

Vice President of Finance and Strategic Planning

Korb Matosich
korb.matosich@aapc.com

Vice President of Marketing

Bevan Erickson
bevan.erickson@aapc.com

Vice President of ICD-10 Education and Training

Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, COBGC, CPEDC, CENTC
rhonda.buckholtz@aapc.com

Directors, Pre-Certification Education and Exams

Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC
raemarie.jimenez@aapc.com
Katherine Abel, CPC, CPMA, CPC-I, CMRS
katherine.abel@aapc.com

Director of Member Services

Danielle Montgomery
danielle.montgomery@aapc.com

Director of Publishing

Brad Ericson, MPC, CPC, COSC
brad.ericson@aapc.com

Managing Editor

John Verhovshek, MA, CPC
g.john.verhovshek@aapc.com

Executive Editors

Michelle A. Dick, BS
michelle.dick@aapc.com
Renee Dustman, BS
renee.dustman@aapc.com

Production Artists

Tina M. Smith, AAS
tina.smith@aapc.com
Renee Dustman, BS
renee.dustman@aapc.com

Advertising/Exhibiting Sales Manager

Jamie Zayach, BS
jamie.zayach@aapc.com

Address all inquires, contributions and change of address notices to:

Coding Edge
PO Box 704004
Salt Lake City, UT 84170
(800) 626-CODE (2633)

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Jun 14	Sacramento, California	Aug 16	Irvine, California
Jun 21	Birmingham, Alabama	Aug 16	St. Louis, Missouri
Jun 21	Monmouth, New Jersey	Aug 23	Virginia Beach, Virginia
Jul 12	Indianapolis, Indiana	Aug 23	Cleveland, Ohio

NOTE: Locations and dates are subject to change.



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Cover the Business Side of Medicine

AAPC recently launched its practice management credential, Certified Physician Practice Manager (CPPM™). During our national conference in Las Vegas, 10 individuals participated in its inaugural training and testing.

CPPM™ for the Non-clinical Business Processes

The CPPM™ credential enables coders, office managers, and practice managers to credential themselves by taking a comprehensive examination covering non-clinical aspects of a physician practice. It covers office processes and workflows, compliance requirements, health care quality, revenue cycle management, inventory management, accounting, human resources (HR), marketing, etc. The examination is the same length as all AAPC certification exams (five hours, 40 minutes) and can be taken at any AAPC testing location. The test is multiple choice and 200 questions. You can get more information on our website at: www.aapc.com/certification/practice-manager-certification.aspx.

With the addition of the CPPM™ credential, we now have the following credentials, which cover most of the business side of a physician practice or facility:

- Coding - Certified Professional Coder (CPC®)
- Auditing - Certified Professional Medical Auditor (CPMA®)
- Compliance - Certified Professional Compliance Officer (CPCO™)
- Practice management - CPPM™

Our goal is to develop a career path for members who wish to pursue careers beyond coding.

Fill Business Needs in Your Practice

For most AAPC members, their career path begins with the CPC® credential, the gold

standard in outpatient coding. If further career advancement is desired, the CPC® can move to either audit (CPMA®), or compliance (CPCO™), and then on to practice management (CPPM™). Thousands of you are ready for this opportunity now. In the long run, physicians will be rewarded with managers who are hands-on, can roll up their sleeves, and are able to perform any task within the practice.

Training for non-clinical exams, beyond the CPC®, is provided in a variety of ways:

- **CPMA® preparation** is accomplished by an online exam review; if additional training is necessary, we offer a two-day preparation class. Both can be found at: www.aapc.com/training/cpma-exam-preparation.aspx.
- **CPCO™ preparation** is accomplished by reviewing AAPC's CPCO™ study guide and online practice test at: www.aapc.com/training/cpco-exam-preparation.aspx.
- **CPPM™ preparation** is accomplished with periodic classroom boot camps (The next one will be in Chicago, Ill. at our fall regional conference, Oct. 25-27), or with our online, pace yourself course, available at: www.aapc.com/training/practice-manager-training.aspx.

Efficiency Is Key

As the physician office continues to evolve, personnel who can wear multiple hats, do multiple tasks, and make the office more efficient will be rewarded. Physicians need people who can improve their practice's financial performance. If you have a desire to advance, consider our new career track credentials.



Sincerely,

A handwritten signature in black ink that reads "Reed E. Pew". The signature is fluid and cursive, written in a professional style.

Reed E. Pew
AAPC Chairman and CEO

JUNE & JULY WEBINARS

- JUN 13** **Denials Management/Analysis**
- JUN 20** **Diabetes Coding**
- JUN 27** **Urgent Care Coding**
- JULY 11** **Ambulatory Surgical Centers**
- JULY 18** **Coding for the Outpatient Hospital Setting**
- JULY 25** **Practice Management: Revenue Cycle Performance Improvement**



TOP RATED 2012 WEBINARS

- JAN 11** **Basics of Auditing**
- JAN 12** **New Health Care Compliance Concerns: Are you at Risk?**
- JAN 25** **What Doctors Want: How to Interact with Doctors Without Reading Their Minds**
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Hot Picks for Your Summer Reading Enjoyment

With summer right around the corner and school letting out soon, there is a lot of talk about summer reading lists. This is a great concept for us in the medical field, as well. There are plenty of articles, books, and other publications I'd like to catch up on. I'm sure you feel the same.

This summer, in addition to the "want to read" books (i.e., catching up with my friends on "The Hunger Games" trilogy by Suzanne Collins), I'll be adding a "must read" category to my list.

Create Your "Must Read" List

Creating a medical coder's summer reading list definitely will look different than the normal summer reading list—no light and easy reading for those in our field. I doubt you'll find a "Chicken Soup for Neurosurgery Coders" or "Romancing the Revenue Cycle" anywhere on the shelf.

Begin your list by identifying those areas you feel you have a weakness in, or an area you have been interested in learning more about (e.g., a new specialty, compliance, health care reform, or health care laws).

I'm not recommending that you rush out and purchase Dr. Louis J. Acierno's "The History of Cardiology" (although the description of the book I Googled does sound pretty interesting), plow through the *Federal Register*, or memorize the Health Care Reform Act. For those overachievers who do dedicate themselves to these reading goals, contact me when you leave the cave. I want to pick your brain for the nuggets of essential information you've processed and add you to my AAPC resource network!

For those who want to read the condensed and regurgitated version of such weighty tomes of information, there are many alternatives from which to choose.

Among the electronic-based favorites of coders and health care administration:

- *Coding Edge, EdgeBlast, Billing Insider, ICD-10 Connect* (www.aapc.com/resources/publications/index.aspx)
- *Coding Alert* – by specialty or focus (www.codinginstitute.com/)
- Pink Sheets
- *Medical Practice Compliance Alert* (<https://store.decisionhealth.com/Product.aspx?ProductCode=MCA>)
- *Part B News* (<http://pbn.decisionhealth.com/>)
- *Coding & Compliance Focus News* (www.medassets.com/ResourceCenter/Pages/CFN.aspx)
- *Modern Healthcare* (www.modernhealthcare.com/)
- *For the Record* (www.fortherecordmag.com/)

Some of these are available by subscription only, but others are free. Many more can be found through online search engines.

Great Reads at Your Fingertips

Sign up and use listserves and forums (e.g., www.aapc.com/memberarea/forums/, www.SuperCoder.com, and <http://healthblawg.typepad.com/>) for a real-time way to plug in and get up to speed on topics related to your summer reading list and career goals.

The *Coding Edge* you have in your hand right now is packed with great reading material, so dive in.

Regardless of what's on your reading list, may it bring you knowledge and success in reaching your coding, billing, and compliance goals.

Enjoy your summer!



Best Wishes,

A handwritten signature in black ink that reads "Cynthia Stewart".

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

New Occurrence Code to Report Date of Death

Effective Oct. 1, 2012, Medicare systems will expect to see on claims a new occurrence code for reporting the date a patient dies.

Providers and suppliers who bill for services provided to Medicare beneficiaries should include occurrence code 55 and the date of death on claims when also including one of the following patient discharge status codes: 20 (expired), 40 (expired at home), 41 (expired in medical facility), 42 (expired - place unknown).

Source: *MLN Matters*® article MM7792 (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7792.pdf), issued April 27, 2012

Temporary Workaround for Organ Donor Complications Billing

Medicare will now separately pay for complication services for a person who donates an organ to a Medicare beneficiary, according to the Centers for Medicare & Medicaid Services (CMS) change request (CR) 7816. With customary claims, the patient is always the beneficiary, so the patient relationship has always been a one-to-one match. When a person donates an organ, how-

ever, the one-to-one patient relationship no longer exists.

CMS has a temporary workaround to allow 837I claims for organ donor complications into Medicare systems. According to *MLN Matters*® article 7816, to code claims for organ donor complications during the temporary process providers should:

- Show the patient relationship of “18” (Self) in form locator (FL) 59 (Patient’s Relation to Insured) on all 837I claims.
- Submit the Medicare beneficiary’s information in the following FLs: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex).
- Add a value of “39” along with the donor’s name to the 837I loop 2300, billing note segment NTE02 (NTE01 = ADD).

Providers using the UB-04 paper claim and direct data should:

- Show the patient relationship of “39” (Organ Donor) in form locator (FL) 59 (Patient’s Relation to Insured); and
- Submit the Medicare beneficiary’s information in the following FLs: 08 (Patient Name/Identifier), 09 (Patient Address), 10 (Patient Birth Date), and 11 (Patient Sex).

For complete instructions, go to CR 7816, at www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R10830TN.pdf or *MLN Matters*® MM7816 www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7816.pdf.

Letters to the Editor

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

Report All Relevant Dx Codes, and Nothing More

I was excited to see the article on diagnosis coding in April (“Diagnosis Code Overload,” pages 14-15); however, I am concerned that the content might lead coders to avoid coding all the diagnoses that are documented in the patient record out of fear of providing too many diagnosis codes that will raise a red flag to auditing entities.

The *Official ICD-9-CM Guidelines for Coding and Reporting*, section IV.K states, “Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.”

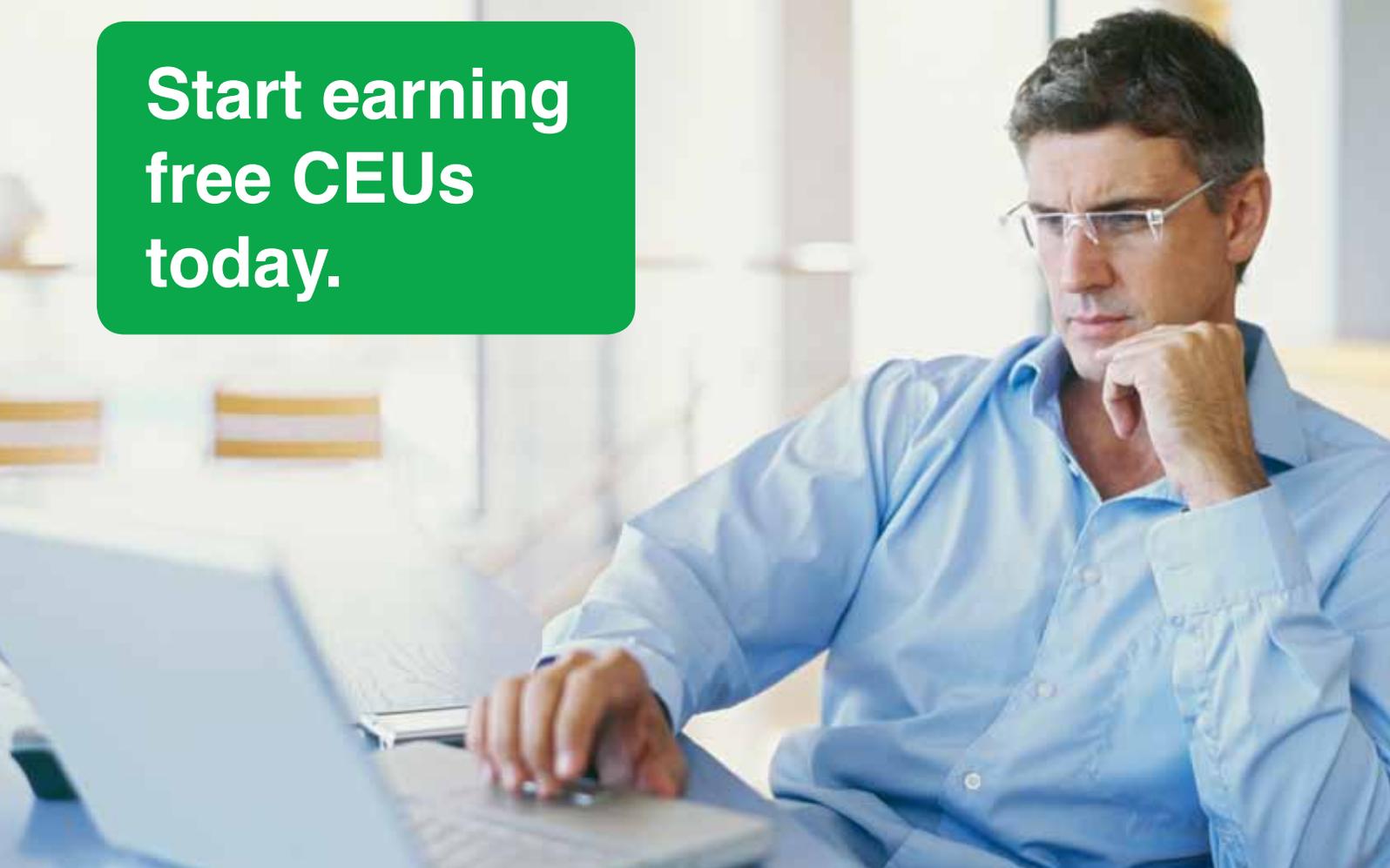
Diagnosis coding is the basis for countless programs for patient care, medical management, and even reimbursement, and failing to code what is there leads to bad data and possibly poor patient care. The requirement (and my personal advice) is to read and understand all of the coding guidelines and follow them.

Serine Haugsness, CPC

You are absolutely correct that coders should report all diagnoses that are relevant to the services rendered at that visit, and which are supported by documentation. The point of **Jeremy Reimer’s, CPC**, article was that coders should report *only* diagnoses relevant to the services rendered at that visit, and which are supported by documentation.

Complete coding is a good thing, for patients, physicians, and insurers; coders should always strive for complete, accurate coding, per the ICD-9-CM guidelines you cite. Complete coding, however, is distinct from “kitchen-sink coding,” which is to cite many ICD-9-CM codes (whether relevant and present, or not) in hope that something will support the procedure coding, and which is fraudulent coding, misleading for providers, and potentially dangerous for patients.

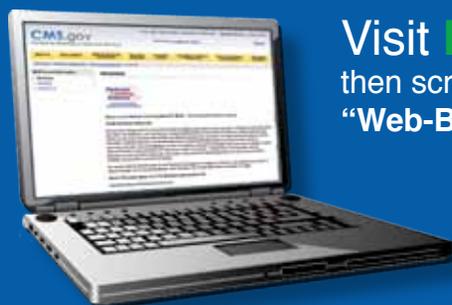
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Networking at Its Best

Realize the possibilities through others' experiences.

This is a true story about a coder who found herself faced with the age-old maxim: You need experience to get a job, but you can't get a job without experience. Not swayed by this roadblock, she mustered the courage to reach out for help, and found others willing to take her hand.

Meet Lara

Lara is a certified coder. She studied, she took the exam, and she passed. Unfortunately, Lara had no coding or medical field experience. She was like many other AAPC members who have asked, "I passed the exam. I am a CPC-A®. Now what?" For Lara that question was answered by her local chapter.

Lara worked to have the "A" removed from her credential, but she had been unsuccessful in securing coding-related employment. She purchased AAPC's virtual experienced exercise, which included 800 op notes, but this became challenging because Lara did not have a networking base to contact when she got stuck on a question. Her solution was to contact fellow chapter members. Even though she was unable to attend chapter meetings, Lara read the chapter newsletter emailed to her each month. Through email, she contacted a fellow chapter member and asked her for help with the difficult coding questions on the exercise. A mentoring relationship soon developed. Lara knew, however, that she also needed hands-on experience, so she asked her new mentor about internships in their area.

Meet Pam

Like others in our field, Pam came with a background in billing and collecting, and was surprised at how much more there was to the coding side. She became so interested in coding she devoured as much information as she could and, with support from her employer, earned her CEDC® credential, making her a double certified AAPC member. Pam also started attending as many local chapter meetings as possible. Through email and chapter meetings, she found she had many similar life experiences and interests with other chapter members, including a desire to help fellow coders.

Seek Opportunity

A classic tale of how networking works: Lara asked her mentor if she knew of any practices offering an internship, and her mentor asked Pam if her practice offered internships. Pam asked her boss if internships were a possibility, and her boss said, "Yes!" Lara began her internship within two weeks.

Benefits for Employer

Although the practice had never considered an internship, the desire to help a future "home grown" coder was intriguing. It allowed the employer to train and observe the skills of a potential employee without making a long-term commitment. Lara had already passed the CPC® exam, showing she had basic coding knowledge, and her eagerness to demonstrate her aptitude through hands-on coding made her a perfect candidate for an internship.

Seasoned Coder Gives Back

Pam understood the challenges new coders face in gaining coding experience and a strong clinical understanding; and, she knew how encouraging her employer was to new coders. Without this support and encouragement, she would not be double certified today. When Pam learned Lara needed experience, she knew this was a chance to help a fellow coder the same way she had been helped.

Benefits for Intern

Every day brings new experiences and knowledge to Lara. She assigns the evaluation and management (E/M) level and ICD-9-CM diagnostic codes. Lara never realized her full potential until working with real charts in the real world. The help and mentoring she has received from her fellow coworkers has been astounding and invaluable.

It's About Networking

The common thread in any mentoring situation is networking. Imagine the difference in this situation's outcome if Pam, Lara, and her mentor were not active AAPC local chapter members, or if the boss had been opposed to a coding intern. Everyone involved saw this situation as an opportunity for all to benefit. Lara gained the experience she needed; Pam encouraged and assisted a fellow chapter member and new coder; her boss was able to evaluate a potential employee; and the mentor was the link that joined them together. It's hard to deny the value of networking demonstrated in this real life story. ☑



Freda Brinson, CPC, CPC-H, CEMC, served from 2009-2012 on the AAPCCA Board of Directors and is compliance auditor for St. Joseph's/Candler Health System in Savannah, Ga. She has 30 years of health care experience. Freda was the 2008 AAPC Networker of the Year and chapter president when Savannah was named 2008 AAPC Chapter of the Year.

Advice from the Involved Networkers

Lara L. Meadows, CPC-A – "Do whatever you can to network. Attend AAPC chapter meetings and don't be afraid to ask around. Even if you think the chances of you getting hired are slim, go for it anyway because you'll never know what amazing experiences might come if you give up and stop trying!"

(Mentor) Freda Brinson, CPC, CPC-H, CEMC – "Attend local chapter meetings; get involved. Network, network, network! You never know when a chance to help or be helped will present itself. Be willing and be ready."

Pamela Jean Herald, CPC, CEDC – "Ask for help! You have nothing to lose and everything to gain. If someone says no, move on, but never stop asking and never give up. This is a great business we are in and there will always be somebody who is going to say, "Yes!"

The Boss – "This has worked out well for our practice. We encourage others to consider this in their practices. It's a win-win situation."



By AAPCCA Secretary Susan Edwards, CPC, CEDC

Are You Receiving All AAPC Updates and News?

When was the last time you verified your AAPC account information online? According to the *Local Chapter Handbook*, chapter 5, section 5.1.1, it's the secretary's responsibility to encourage members to update the following information on the AAPC website:

- Name
- Email address
- Mailing address
- Phone numbers
- The chapter to which you are assigned
- Access to your account

To update your information, log in to www.aapc.com and hover your mouse over the "My AAPC" tab at the top right of your screen to activate a pop-up menu with several links. Click the "Profile/Preferences" link under the "My Account" section. This will take you to the "Contact Info" tab on the "Account Profile" page, where you can update your contact information and specify which AAPC publications you want to receive.



On the "Work" and "Specialties" tab you can add additional information. All of this information will help AAPC match you with job opportunities, pertinent information, tools, and member benefits.

You also can sign up to receive notification

of other chapter meetings in your area, or in an area you may visit, and update your chapter affiliation if you relocate. This information is located under the "Local Chapters" tab.

There are many other resources available through the "My Account" navigational links to the left. Take a few moments to explore the "Event Calendar," "Resources," and "Benefits" for members. You'll be pleasantly surprised at the wealth of information available to you.

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Be Aggressive with Same-day E/M and Office Procedure

Fight for your right to be paid for properly documented claims.



When commenting on **Abraham Morse's, MD, MBA**, article "Same-day E/M and Office Procedure: Yes, You Can!" (March 2012 Coding Edge, pages 16-17), several readers shared that insurers (including Medicare contractors) routinely deny evaluation and management (E/M) claims when reported with other procedures on the same day, and asked how to avoid such denials. The answer is three-fold: Know the applicable guidelines, be ready to submit documentation to backup your claim, and pursue appeals aggressively to get the payment you deserve.

Know the Guidelines

Under both the Centers for Medicare & Medicaid Services (CMS) and CPT® guidelines, an E/M service may be separately billed with a mi-

nor procedure as long as the E/M service was clearly documented and substantiated and modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service* is properly appended to the appropriate E/M service code.

CMS transmittal R954CP (*Medlearn Matters* number: MM5025, change request (CR) 5025) instructs coders to apply modifier 25 for "a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work for the service," and to "appropriately and sufficiently" document medical necessity for both the E/M service and the other service or procedure.

Both the procedure and the separate, same-day E/M service must be linked to an approved diagnosis, substantiated in the medical record. The diagnoses supporting each service may be the same or different. Per transmittal R954CP, "The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, *different diagnoses are not required for reporting of the E/M services on the same date*" [emphasis added].

The American Medical Association (AMA) guidelines, as outlined in the CPT® codebook and *CPT® Assistant*, also clearly and consistently support coding for a minor procedure and a separate, significant same-day E/M with modifier 25. Below are three such examples from *CPT® Assistant*, involving varying specialties and spanning nearly 20 years.

Example 1 (Winter 1993, *CPT® Assistant*):

"A physician examines a patient with a fever,

headache, vomiting, and stiff neck. A spinal tap is performed as well as the services described in code 99214. The -25 modifier is appended to code 99214 to indicate that both a significant E/M service and a procedure were performed on a given day."

Example 2 (May 2003, *CPT® Assistant*):

"A physician examines a new patient exhibiting symptoms of an upper-respiratory infection that has progressed to unilateral purulent nasal discharge and discomfort in the right maxillary teeth. The physician performs and documents a detailed history and detailed examination. The physician determines that the medical decision making is of low complexity and also documents this in the patient's medical record. This new patient encounter is reported with E/M service code 99203 *Office or other outpatient visit*.

During the examination, the patient communicates to the physician that the hearing in his left ear is not as distinct as his right ear. Upon examination of the left ear, the physician notes a large amount of impacted cerumen. The physician proceeds to suction the impacted cerumen in the patient's left ear.

To report this patient encounter, the physician appends Modifier '-25' to code 99203, and separately reports code 69210, *Removal impacted cerumen (separate procedure), one or both ears* to indicate that both a significant E/M service and a procedure were performed on a given day."

Example 3 (May 2011, *CPT® Assistant*):

"A 4-year-old slips on the edge of a pool, strikes the mandible and experienced a 3.5 cm serrated and curvilinear, full-thickness laceration of

Takeaways:

- Documentation should include a clear history, exam, and medical decision-making apart from any other procedures the physician performs on the same day to report a separate E/M service with modifier 25.
- Different diagnoses are not required to report an E/M service on the same date as another procedure or service.
- Medicare contractors may impose prepayment requirements on modifier 25 claims only if the payer has specific evidence of misuse or abuse.



Per national CMS policy, Medicare contractors may impose prepayment requirements on modifier 25 claims only if the payer has specific evidence of misuse or abuse.

the chin. The child's pediatrician elects to widely excise the serrated skin margins and undermine the dermis from the subcutaneous tissue to reduce the tension on the suture line. The wound is then approximated in layers with absorbable interrupted sutures and a running subcuticular closure.

This procedure would be reported with code 13132 *Repair complex, forehead, cheeks, chin, mouth neck, axillae, genitalia, hands and/or feet; 2.6 to 7.5 cm*. Any significant, separately identifiable evaluation and management (E/M) service performed in addition to the wound repair would be reported separately using modifier 25."

Document to Support Your Claim

All services and procedures include an "inherent" E/M component. A brief history and physical prior to a same-day scheduled outpatient procedure are included components of the procedure itself. Even if the physician provides an assessment and plan, you probably should not report a separate E/M service unless the patient has a new, unrelated complaint or has experienced a worsening of symptoms that prompts a new history, exam, and medical decision-making (MDM) process that might include additional testing or therapy.

The question persists: How do you decide if an E/M service is truly "significant" and "separately identifiable" (and separately reportable with modifier 25)? Ask yourself, "Can I pick out from the documentation a clear history, exam, and MDM apart from any other procedures the physician performs on the same day?" If so, you've probably got a billable service with modifier 25.

MYTH BUSTER: Coding legend has it that an E/M service must reach at least a "level-III" service (e.g., 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity* for a new office patient, or 99213 *Office or other outpatient visit for the evaluation and management of an estab-*

Beware of Modifier 25 Exceptions

There are three specific circumstances under which the normal requirements for billing a separate E/M service with a same-day minor procedure do not apply, per the *Medicare Claims Processing Manual*, publication 100-04, chapter 12, section 30.6.6.B:

1. "When inpatient dialysis services are billed (CPT® codes 90935, 90945, 90947, and 93937), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure.
2. When preoperative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure.
3. Carriers may not permit the use of modifier 25 to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT® definition of the modifier."

lished patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity for an established office patient) to qualify as "significant," as defined by modifier 25. However, this requirement appears nowhere in CMS guidelines; and according to *CPT® Assistant* (September 1988), modifier 25 "is not restricted to a particular level of service."

To support your claims further, when an E/M service leads to an unplanned, same-day procedure, be sure that documentation clearly shows the decision to perform the procedure was made during the encounter.

Per CMS transmittal R954CP, you do not need to submit full documentation with your claim, but the documentation must be available upon request (this will be important for our next step).

Rejected? Appeal!

Several readers have had an experience similar to that of an AAPC member who told us, "I just got off the phone with [her state] Medicare, and they say their system is set to flag E/M codes billed with procedures done on [the] same day. Claims may be denied if the codes are billed with [the] same diagnosis. The only way to get payment is to appeal." Another reader commented that her insurer never allows separate billing for a same-day E/M and procedure.

If your Medicare payer routinely denies modifier 25 claims, drop a little knowledge on them: Per national CMS policy, Medicare contractors may impose prepayment requirements on modifier 25 claims only if the payer has specific evidence of misuse or abuse. This instruction is detailed in the *Medicare Claims Processing Manual*, publication 100-04, chapter 12, section 30.6.6.B:

"When a carrier has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of modifier '-25' compared to other physicians, has done a case-by-case review of the records to verify that the use of modifier was inappropriate, and has educated the individual or group, the carrier may impose prepayment screens or documentation requirements for that provider or group."

In every case, if you've received a denial for a clean claim supported by documentation, be sure to appeal. Yes, appeals mean extra work, but the coding guidelines are clearly stated and on your side, and consistently writing off these claims can have a calamitous effect on the practice's bottom line.

Tip: For more information on how to pursue appeals, see "Appeal Claims Strategically to Capture Revenue You Deserve" on page 42 in this issue of *Coding Edge*. [\[E\]](#)

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

2012 Best Practices for ICD-10-CM Documentation and Compliance

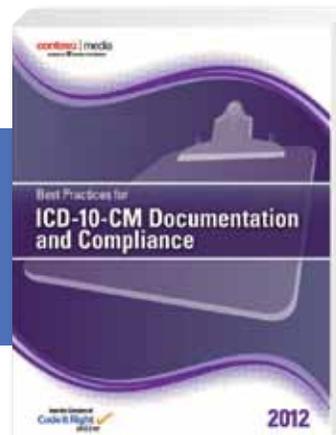
Understanding the new documentation requirements for ICD-10-CM is vital to a successful transition to ICD-10. ICD-10-CM requires more detailed documentation for assignment of the most specific diagnosis code(s).

The **2012 Best Practices for ICD-10-CM Documentation and Compliance** addresses the documentation analysis phase of ICD-10-CM coding and provides all the tools required for an effective documentation analysis and a corrective action plan including:

- **Comprehensive review of each ICD-9-CM chapter and the corresponding ICD-10-CM chapter** or chapters with identification of diagnoses/conditions requiring additional documentation and discussion of the relevant coding guidelines and coding notes
- **An ICD-9-CM to ICD-10-CM comparison of code categories and subcategories** requiring more specific documentation
- **A table with ICD-9-CM codes and the applicable ICD-10-CM codes** for the same condition
- **Checklists to identify the new documentation elements** for categories, subcategories and/or codes in ICD-10-CM
- **Scenarios showing required documentation in ICD-9-CM and ICD-10-CM** with the additional documentation elements in ICD-10-CM highlighted
- **Codes (ICD-9-CM and ICD-10-CM) and explanations including applicable guidelines** for each scenario
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By Brad Ericson, MPC, CPC, COSC

Coders Cash Chips at Conference for Coding Connection

Like its location, 2012 AAPC National Conference proves spectacular.

When you want to do something big and spectacular like an AAPC National Conference, do it in Las Vegas. The largest AAPC conference ever, both in attendees and content, the 2012 national conference reflected the new reality for coders, biller, auditors, and others in our industry.

“AAPC members are really beginning to understand that being a coder is about more than ‘just coding,’” said **Cynthia Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P**, president of the National Advisory Board (NAB). “We are asking for education at conference to develop the building blocks needed to move beyond or break through the ‘just coding’ mentality of the industry.”

More Sessions Offered as Coding Expands

Expanding roles brought about by new electronic tools and standards, increasing scrutiny from payers, new medical and coding techniques and guidelines, and the advent of ICD-10 prompted organizers to expand the number of break-out sessions to 72, plus add pre-and post-conference boot camps.

Break-out sessions were supplemented by the Anatomy Expo and the keynote presentation presented by **Brad Barton, CSP**, who used his skills as a magician to demonstrate how we all have the magic of success inside of us.

The focus throughout the conference remained on coding’s changing role, which speaker after speaker emphasized is the key to facing the future of health care. Additional sessions on compliance, billing, documentation, ICD-10, and advanced techniques in health care helped drive their points home.

AAPCCA's Energy Is Contagious

Local chapters whooped it up again this year. AAPC Chapter Association (AAPCCA) Board of Directors had fun training local chapter officers; and local chapters gathered at the cryptically named G2KYL (Get to Know Your Local Chapter) to show off what makes each special.

“There was such energy at conference this year!” said **Brenda Edwards, CPC, CPMA, CPC-I, CEMC**, vice-chair AAPCCA Board of Directors. “Networking oppor-



Figure Captions:

1. Chairman and CEO Reed E. Pew
2. Brad Barton, CSP, creates a magical impression.
3. Singing Elvises herald ICD-10.

4. Richard Reyna, Kathy Burke at region competition
5. Elvis is in the building!
6. Opening skit lightens start-up.
7. The jury is in: Everyone is guilty of having fun!



Figure Captions:

- 8. David Dunn, MD, presents break-out session.
- 9. Attendees reconnect.
- 10. Local chapters unite for a good cause.

- 11. Humor is the best medicine.
- 12. GTKYLC fun
- 13. NAB President Cynthia Stewart
- 14. Exhibitors have something for everyone.

“The speakers were wonderful and showed us the new directions we may be moving towards in the future of our coding careers, such as auditing, educating, and consulting.”

tunities were abundant and the veteran attendees made the first time attendees feel very welcome. I personally witnessed this on multiple occasions when a new attendee was searching for others from their area or region. The speakers were wonderful and showed us the new directions we may be moving towards in the future of our coding careers, such as auditing, educating, and consulting. With EMR, ICD-10, and all of the other initiatives on the horizon, coders will be a highly sought-after commodity.”

AAPC’s Shining Stars

The 2011 Coder of the Year, **Peggy Green, CMA, CPC, CPC-I, CPMA**, and Local Chapter of the Year, **Springfield, Mo.**, were honored at the conference for their outstanding contributions to AAPC and its members. President and CEO **Reed Pew** and NAB President Stewart spoke in general sessions.

Networking, Shopping, and Sightseeing

No professional conference is complete without the personal experiences of making and renewing friendships, discussing jobs and techniques, and exploring and dining together. Field trips to the Hoover Dam, shopping expeditions, and sight-seeing on the Las Vegas Strip freed members’ minds from the sessions they attended. “As I looked around and spoke to attendees, it was obvious to me that everyone was having a great experience,” **David Dunn, MD, FACS, CPC-H, CIRCC, CCC, CCS, RCC**, NAB president-elect, told *Coding Edge*.

More Conference Excitement to Come

AAPC offers a regional conference in Chicago, Oct. 25-27, meant to spread the knowledge and vigor found at this year’s national conference. Attendees are excited to keep the positive energy high. “The energy of our members at this year’s conference was phenomenal,” Stewart said. “This year’s conference far surpassed our expectations in more ways than the sheer number of members who committed themselves to the education and networking opportunities. I’m looking forward to regional; I hope to see many members there, and a continuance of this positive momentum.”

Brad Ericson, MPC, CPC, COSC, is director of publishing and warehouse at AAPC.

CaseCoderExtreme™

Primary Insurance
 Ins. Phone #: 5152226262
 Spoke With: Jane West
 Active: Yes
 Effective Date: 4/1/2011
 Insured: patient
 ID #: 12312321312
 Group #:
 Ins. Mailing Address 1: 1 Watch Way
 Ins. Mailing Address 2: Anywhere NY
 Plan Type: priv
 Par/Non Par: Non Par
 Physician Category: Surgeon
 In Patient/Out Patient: In Patient
Workers' Comp
 Ins. Phone #: 21313132
 DOI:
 Claim #:
 Employer:

Secondary Insurance
 Ins. Phone #:
 Spoke With:
 Active:
 Effective Date:
 Insured:
 ID #:
 Group #:
 Ins. Mailing Address 1:
 Ins. Mailing Address 2:
 Plan Type:
 Par/Non Par:
 Physician Category:
 In Patient/Out Patient:
Auto
 Ins. Phone #:

Decompression

Trayning, Ian MD

P/E	CPT CODE	MOD	FEES	# OF UNITS	TOTAL BILLED	EOB1	EOB2	TOTAL PAID	MIN EXP. PAYMENT
P	22558	62	\$ 43,750.00	1	\$ 43,750.00				\$ 3,125.00
E	22851		\$ 10,382.00	1	\$ 10,382.00				\$ 1,590.00
E	22845		\$ 18,360.00	1	\$ 18,360.00				\$ 2,300.00
TOTAL BILLED					\$ 72,492.00				\$ 7,015.00
TOTAL ALLOWED \$									

Co-Surgeon: Cuttin, Will B MD

P/E	CPT CODE	MOD	FEES	# OF UNITS	TOTAL BILLED	EOB1	EOB2	TOTAL PAID	MIN EXP. PAYMENT
P	22558	62	\$ 43,750.00	1	\$ 43,750.00				\$ 3,125.00
E	22851	80	\$ 5,191.00	1	\$ 5,191.00				\$ 259.17
E	22845	80	\$ 9,180.00	1	\$ 9,180.00				\$ 374.90
TOTAL BILLED					\$ 58,121.00				\$ 3,759.07
TOTAL ALLOWED \$									

Billing Encounter Form
 Account #: 12312321312
 Patient Name: Emma Hurtin
 Date of Service: 11/15/2011
 Place of Service: Texas Hospital
 Primary Insurance: Texas Insurance
 Plan Type: priv
 Authorization #: 2232132
 ICD-9 Codes: 722.0, 722.71
 Secondary Insurance:
 Plan Type:
 Authorization #:
 Previous SX

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What's the Word on GERD?

Find out the latest on gastroesophageal reflux diagnosis and treatment coding.

Gastroesophageal reflux is the backward flow of the gastric contents into the esophagus due to improper functioning of the lower esophageal sphincter (also called the cardiac sphincter). Gastroesophageal reflux disease (GERD), ICD-9-CM 530.81 *Esophageal reflux*, is a highly variable, chronic condition characterized by periodic episodes of gastroesophageal reflux, accompanied by heartburn, which may damage the esophagus.

Coding Diagnostic Procedures

Common procedures to diagnose GERD include esophageal pH testing and impedance testing. Patients scheduled for pH and/or impedance monitoring often are tested for a 24-hour period while off any proton pump inhibitor (PPI) medication.

Reported with CPT® 91034 *Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation* and 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation*, esophageal pH testing measures acid reflux in the esophagus. Code 91035 specifically describes the Bravo™ pH Monitoring system, or “Bravo capsule.”

Impedance testing is similar to esophageal pH testing, but is a newer technique that measures gas or liquid reflux into the esophagus. It is useful in patients who have reflux of substances that are not acidic, and would not be detected by an esophageal pH study.

Impedance testing is reported using one of two codes, depending on the duration of testing (which should be documented in the medical record):

91037 Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;

91038 prolonged (greater than 1 hour, up to 24 hours)

Codes 91037 and 91038 may be used alone or in combination with the esophageal pH study (91034 and 91035). In patients with refractory reflux, combined impedance and pH monitoring might provide the best strategy for evaluation of reflux symptoms.

Like the esophageal pH study, impedance testing uses a small catheter passed through the nose, into the esophagus. The catheter is attached to the recording device (worn around the patient's waist), and the patient is asked to perform his or her regular daily activities.

Turn to 26 for Professional-only Services

A trained physician reads and interprets esophageal pH studies and/or impedance studies when they are complete. If the billing physi-

Takeaways:

- GERD is a highly variable, chronic condition characterized by periodic episodes of gastroesophageal reflux, accompanied by heartburn, which may damage the esophagus.
- GERD testing and procedural coding require the use of technical and professional modifiers.
- When GERD is being treated, be especially watchful of the services performed on the patient to guarantee coding accuracy.

cian does not own the testing equipment, or if testing is done as an outpatient hospital procedure, bill for the test interpretation and reading only by appending modifier 26 *Professional component* to the appropriate testing code(s).

For example, a patient presents for outpatient impedance testing. After informed consent is obtained, the patient is placed in the sitting position. The impedance electrode is inserted by a transnasal approach and placed approximately 5 cm above the lower esophageal sphincter. The patient is released.

The next day, the physician interprets the recorded data and assigns a Johnson-DeMeester score. A reflux episode (or non-reflux, as in additional impedance testing) is defined as an esophageal pH drop below four. There are six parameters to obtain the analysis score:

1. Percent total time pH < 4
2. Percent upright time pH < 4
3. Percent supine time pH < 4
4. Number of reflux episodes
5. Number of reflux episodes ≥ 5 min.
6. Longest reflux episode (minutes)

A typical reflux patient could have a score lower than four for each parameter, for 80 percent of the 24-hour period. Acid-related and non-acid-related episodes are measured in the upright and supine positions.

In our example, the physician will report 91038-26 for her interpretation.

Treatment May Include Surgical Options

Pharmaceutical treatment for esophageal reflux usually includes proton pump inhibitors (PPIs), which are medications that decrease the amount of acid in the stomach and intestines. Based on the results of esophageal pH studies and/or impedance studies, the provider may increase PPI dosage for patients whose acid is poorly controlled. If a symptomatic patient is refluxing, but acid levels are low, the provider could consider antispasmodics or tricyclic antidepressants.



Impedance testing is similar to esophageal pH testing, but is a newer technique that measures gas or liquid reflux into the esophagus.

sants at low doses, which block the pain pathway from the stomach to the brain.

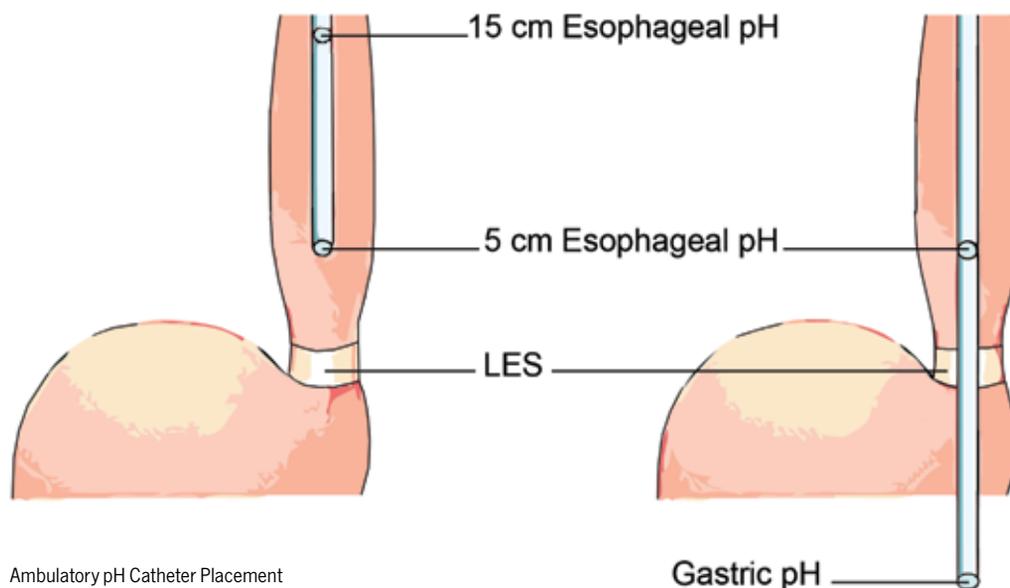
When the patient experiences regurgitation and acid uncontrolled by PPIs, a surgical intervention known as laparoscopic Nissen fundoplication may be necessary, says gastroenterologist **Michael F. Sheffield, MD**, of Gastroenterology Specialists of Oregon, P.C. The patient would need to be referred to a general surgeon or surgeon who performs the procedure.

The technique, developed by **Dr. Rudolph Nissen** (1896-1981), involves placating (wrapping) the upper part of the stomach (the gastric fundus) around the lower end of the esophagus and stitching it in place. This reinforces the crossing function of the lower esophageal sphincter so when the stomach contracts, it closes off the esophagus rather than squeezing stomach acids into the esophagus.

Proper coding for laparoscopic Nissen fundoplication is 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)*. Be aware that a Nissen procedure may occur in addition to paraesophageal hernia repair. When this occurs, choose either 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* or 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh*, depending on whether the surgeon uses mesh during the repair. Do not report 43280 in addition to 43281 or 43282; both hernia repair codes bundle (include) the fundoplasty.

Open Approach Calls for Dedicated Coding

Less commonly, Nissen procedures may be performed by an “open” approach, to include 43327 *Esophagogastric fundoplasty partial or complete; laparotomy* to report esophagogastric fundoplasty with gastroplasty by laparotomy (stomach incision), or 43328 *Esophagogastric*



fundoplasty partial or complete; thoracotomy to report esophagogastric fundoplasty with gastroplasty by thoracotomy (chest incision). Codes 43332-43337 describe open paraesophageal hiatal hernia repair by various approaches (laparotomy, thoracotomy, and via thoracoabdominal incision), with or without mesh implantation, and also include fundoplication, when performed. Do not report 43327 or 43328 in addition to 43332-43337.

Cite Add-on Codes for Esophageal Lengthening

In addition to fundoplasty, surgeons may perform an esophageal lengthening procedure to reverse esophageal shortening due to advanced reflux stricture or ulceration. These procedures may be performed laparoscopically (+43283 *Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)*), or by an open approach (+43338 *Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)*).

When performed, report laparoscopic add-on procedure 43283 with 43280, 43281, or 43282. You may report an open esophageal lengthening procedure (+43338), when properly documented, with a laparoscopic Nissen fundoplasty (43280), or open repairs 43327-43337.



Rebecca M. Hovis, CPC, CPC-P, CGIC, has been in the health care field since 1995, when she obtained her medical receptionist certificate at Clackamas Community College Oregon City, Ore. She has been employed at Gastroenterology Specialists of Oregon, P.C. since 1997, and has been coding at the 15-practitioner office since 2008.

Add Therapeutic Procedures and Modalities to a Chiropractic Practice

It's a worthwhile venture, but document and code claims carefully to get paid.

Adding therapeutic procedures and modalities can be a great adjunct to a chiropractic practice. Many doctors of chiropractic medicine incorporate therapeutic procedures and modalities, and most insurance carriers (except Medicare) will reimburse chiropractors for them.

Supervised Modalities

Supervised modalities include application of a modality to one or more areas not requiring direct (one-on-one) patient contact by the provider. Supervised modalities examples include:

Mechanical traction (97012 *Application of a modality to 1 or more areas; traction, mechanical*) is used to separate and stretch the spinal segments, promote distraction, and gliding of the joint facets to help promote joint hydration.

Electrical stimulation, unattended (97014 *Application of a modality to 1 or more areas; electrical stimulation (unattended)*) and G0283 *Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care*) is used to treat edema, inflammation, muscle spasm, limited mobility, atrophy, wound care, and re-education of muscle function.

Constant Attendance Modalities

Constant attendance modalities include the application of a modality to one or more areas, and require direct (one-on-one) patient contact by the provider. Constant attendance modalities examples include:

Electrical stimulation, attended (97032 *Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 min-*

Takeaways:

- Therapeutic procedures are beneficial to a chiropractic practice.
- There are several therapies and modalities in the CPT® 97000 series that may be billed.
- The codes are often billed by increments of time.

utes): High volt electrical muscle stimulation is used to help reduce pain and muscle spasm. It also helps to reduce inflammation and promote tissue healing and repair. Low frequency electrical muscle stimulation helps with the reduction of post-traumatic inflammation, reduces swelling, and promotes wound healing.

Ultrasound (97035 *Application of a modality to 1 or more areas; ultrasound, each 15 minutes*) is used to provide a deep, penetrating heat effect within the tissue. Ultrasound introduces a micro-massage within the tissue by breaking down scar tissue and reducing edema.

Therapeutic Procedures

Therapeutic procedures affect change through the application of clinical skills and/or services to improve function. Physicians or therapists are required to have direct (one-on-one) contact with the patient.

Therapeutic procedures are generally coded and billed on the basis of the intended outcome, not on a device or piece of equipment (in contrast to modalities, which generally are coded and billed based on the device used). When billing and coding for therapeutic procedures, be sure to document the intended clinical outcome, as well as how the procedure is performed. The relationship to a functional activity is important to document in the treatment plan. An example might be, "Increase flexibility of the quadratus lumborum muscles while activating and stretching the hamstring muscles to

improve the patient's capacity for walking and standing."

Therapeutic procedure examples include:

Therapeutic exercises (97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*) are performed in either an active, active-assisted, or passive approach (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening). The exercises may be reasonable and medically necessary for a loss or restriction of joint motion, strength, functional capacity, or mobility that has resulted from a specific disease or injury. Documentation must show objective loss of joint motion, strength, or mobility (e.g., degrees of motion, strength grades, levels of assistance). Therapeutic exercises are used to increase range of motion, flexibility, endurance, and strength.

Neuromuscular re-education (97112 *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities*) is used to improve balance, coordination, kinesthetic sense, and proprioception (the sense of the relative position of neighboring parts of the body and effort employed in movement.). This procedure is reasonable and medically necessary for impairments affecting the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordi-



One difference between 97124 and 97140 is the intention of the therapy.

nation, and hypo/hypertonicity). Examples include proprioceptive neuromuscular facilitation (PNF), the Feldenkrais method, Bobath, Bap's Boards, and desensitization techniques.

Aquatic therapy with therapeutic exercises (97113 *Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises*) are used for a loss or restriction of joint motion, strength, mobility, or function resulting from a specific disease or injury. Documentation must show objective loss of joint motion, strength, or mobility (e.g., degrees of motion, strength grades, or levels of assistance). Exercises are performed in a water environment and in a non-weight bearing position.

Gait training (97116 *Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)*) should be used for training patients whose walking abilities are impaired by neurological, muscular or skeletal abnormalities, or trauma. This procedure should not be used when the patient's walking ability is not expected to improve.

Massage therapy (97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)*) could be used as a preparatory procedure on the same day as a therapeutic procedure to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm. It should be related to other therapeutic procedures within the overall plan of treatment. This therapy includes effleurage, petrissage, and/or tapotement (stroking, compression, percussion) and is used to reduce spasms and stiffness.

Manual therapy techniques (97140 *Man-*



ual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes) include soft tissue and joint mobilization, manipulation, manual lymphatic drainage, manual traction, trigger point therapy (non-injectable), and myofascial release. Manual therapy techniques are used to treat restricted motion of soft tissues in the extremities, neck, and trunk, and are used in an active and/or passive fashion to effect changes in the soft tissues, articular structures, neural, or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue.

97124 vs. 97140

One difference between 97124 and 97140 is the intention of the therapy. If you are performing therapeutic massage to increase circulation and promote tissue relaxation to the muscles, and the treatment is based on or consists of a basic relaxation massage, use 97124. If, however, your intention is to

increase pain-free range of motion and facilitate a return to functional activities, use 97140.

Be aware, also, of the National Correct Coding Initiative (NCCI) edits created by the Centers for Medicare & Medicaid Service (CMS), which require manual therapy techniques, massage therapy, and neuromuscular re-education be performed in a separate anatomic region than the chiropractic adjustment. When appropriate, attach modifier 59 *Distinct procedural service* to 97112, 97124, or 97140 to indicate it is a distinct procedure and is being performed on a different anatomic site than the chiropractic manipulative therapy (CMT).

Billing for Units

For any single timed CPT® code on the same day measured in 15-minute units, billing for units is as follows:

- 1 unit = 8-22 minutes
- 2 units = 23-37 minutes
- 3 units = 38-52 minutes
- 4 units = 53-67 minutes



If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations could be highlighted for review.

If a service represented by a 15-minute timed code is performed in a single day for at least 15 minutes, bill that service for at least one unit. If the service is performed for at least 30 minutes, bill that service for at least two units, etc.

It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes. When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service (as noted in the chart on the previous page) determines the number of timed units billed.

If any 15-minute timed service performed

for seven minutes or less on the same day as another 15-minute timed service also performed for seven minutes or less, and the total time of the two is eight minutes or greater, bill one unit for the service performed for the most minutes. Apply the same logic when three or more different services are provided for seven minutes or less.

The expectation is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations could be highlighted for review. If more than one 15-minute timed CPT® code is billed during a single calendar day, the total num-



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Understand Medical Necessity

One of the most important items relating to therapeutic procedures and modalities is establishing medical necessity. Per the Centers for Medicare & Medicaid Services (CMS), medical necessity is a service, treatment, procedure, equipment, drug, or supply provided by a hospital, physician, or other health care provider that is required to identify or treat a beneficiary's illness or injury, and which is (as determined by the contractor):

- Consistent with the symptom(s) or diagnosis and treatment of the beneficiary's illness or injury;
- Appropriate under the standards of acceptable medical practice to treat that illness or injury;
- Not solely for the convenience of the participant, physician, hospital, or other health care provider; and
- The most appropriate service, treatment, procedure, equipment, drug, device, or supply which can be safely provided to the beneficiary and accomplishes the desired end result in the most economical manner.

The provided items or services must be reasonable and necessary for the diagnosis or treatment of the illness or injury or to improve the functioning of a malformed body member.

Diagnoses Done Right

Therapeutic procedures and modalities billed to insurance carriers must be supported by your diagnoses, and the diagnoses must be substantiated by documentation. The clinical rationale for choosing a diagnosis must be in writing and entered in the patient chart. The diagnoses you choose represent your patient's condition to insurance carriers and should be extremely accurate.

Accuracy is also important when incorporating certain rehabilitation procedures. For example, if you plan on using myofascial release (97140) on the shoulder, a soft tissue diagnosis such as 719.51 *Stiffness of joint, not elsewhere classified, shoulder region* would be appropriate.

Insurance carriers can look for diagnosis codes that were truncated (shortened or condensed). Many carriers require diagnoses to be reported to the "highest degree of specificity." This means that if the patient presents with a chief complaint that can be reported with a 5-digit diagnosis code, use it.

During the initial patient visit, you may come up with a "probable," "suspected," or "working" diagnosis. Use caution in this situation: Code to the highest degree of certainty for that patient encounter, to include signs, symptoms, subluxation levels, diagnostic test results, or other reason for the visit.

You may also face a situation when a diagnosis cannot be established at the time of the initial encounter. It's OK to take two or more visits before a diagnosis can be confirmed. You're better off waiting a few visits to submit a claim that has a definitive diagnosis than submitting an incorrect diagnosis code.

ber of timed units that can be billed is constrained by the total treatment minutes for that day.

The amount of time for each specific modality and therapeutic procedure provided to the patient should be documented in the subjective, objective, assessment, and plan (SOAP) notes.

Example No. 1

8 minutes of therapeutic exercise (97110)

8 minutes of manual therapy (97140)

TOTAL = 16 timed minutes

The appropriate billing in this example is one unit. You should select 97110 or 97140

to bill because each unit was performed for the same amount of time and only one unit is allowed.

Example No. 2

7 minutes of neuromuscular re-education (97112)

7 minutes of therapeutic exercise (97110)

7 minutes of manual therapy (97140)

TOTAL = 21 timed minutes

The appropriate billing in this example is one unit. You should select one code (97112, 97110, or 97140) to bill because each unit was performed for the same amount of time and only one unit/one code is allowed.

Example No. 3

33 minutes of therapeutic exercise (97110)

7 minutes of manual therapy (97140)

TOTAL = 40 timed minutes

The appropriate billing in this example is three units. Bill two units of 97110 and one unit of 97140, and count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example No. 4

24 minutes of manual therapy (97140)

23 minutes of therapeutic exercise (97110)

TOTAL = 47 timed minutes

The appropriate billing in this example is three units. Each service is performed for more than 15 minutes, so bill each for at least one unit. The correct way to code this example is two units of 97140 and one unit of 97110, assigning more timed units to the service that took the most time.

Example No. 5

18 minutes of therapeutic exercise (97110)

13 minutes of manual therapy (97140)

10 minutes of therapeutic activities (97530)

8 minutes of ultrasound (97035)

TOTAL = 49 timed minutes

The appropriate billing in this example is three units. You should bill the procedures you spent the most time providing. Bill one unit each of 97110, 97140, and 97530. You should not bill for the ultrasound because the total time that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill four units for less than 53 minutes, regardless of how many services were performed). You should document the ultrasound in the SOAP notes.

In an upcoming issue, we'll discuss group therapy coding and coding for unlisted modalities. 



Marty Kotlar, DC, CHCC, CBCS, is the president of Target Coding (www.TargetCoding.com). He has been helping chiropractors with reimbursement issues using proper and compliant CPT® coding for more than 10 years. Dr. Kotlar can be reached at drkotlar@targetcoding.com.

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Springfield, Mo. Chapter Puts Compassion to Work

With coding and caring at the core of motivation, amazing things happen.



2011 Springfield, Mo. chapter officers, from left to right: Back row - Danne Ryan, Delynn Perryman, Eva Speck; Front row - Michelle Stallings, Amy Bishard, Betsy Gundersen

AAPC is proud to present the 2011 Chapter of the Year award to Springfield, Mo.

The Springfield local chapter officers made earning this award a goal early in 2011, but according to 2011 President **Amy Bishard, CPC, CPMA, CEMC, RCC**, “The real motivation was putting together a process that would improve our local chapter.” The officers began setting goals and working hard together to achieve their goals. Springfield won the 2011 Chapter of the Year award because mem-

bers are “hard working,” said the Springfield chapter’s 2011 secretary, **Betsy Gundersen, CPC, CCS-P**. “We have moved from a small group of eight to 12 individuals, to nearly triple that at some of our monthly meetings. We have worked to provide quality education and an element of fun and companionship.” Amy agreed, saying the chapter has grown tremendously in the past two years. “As a result of member recruitment, the overall membership has grown by almost 40 percent and meeting attendance has more than doubled,” said Amy. Members represent all aspects of the field, according to Amy.



Letter to Lighten the Load

When disaster struck in Joplin, Mo., this heartfelt email was sent to the four surrounding states' local chapter officers from Springfield, Mo. 2011 Local AAPC Chapter President **Amy Bishard, CPC, CPMA, CEMC, RCC:**

The Little Chapter that Could

While Springfield was busy raising the bar of excellence for their chapter, a devastating EF-5 tornado struck in nearby Joplin, Mo. When Springfield received word of the tornado's destruction, they leaped into action, proving that with a little compassion for others and a passion for coding they could do great things.

"As a chapter, we reached out to provide them with any assistance we could," Betsy said. "Our officers contacted members of the Joplin chapter and tried to fill specific needs such as coding books, review classes, and exams; as an entire chapter, we also donated time, money, and supplies to the Joplin community."

Springfield discovered they are small, but mighty. They are the "Little Chapter that Could," as 2011 Education Officer **Danne Ryan, CPC**, put it. Betsy said, "We can be coding professionals and care for our extended community, not just our chapter family. Like the 'Little Engine that Could,' we became the little chapter that DID."

Springfield Springs into Action

As soon as the Springfield chapter realized the magnitude of devastation in Joplin and that a major hospital was destroyed, they knew members of their sister chapter were hurting. Amy said, "Within the first week, our members had already donated coding books and scrubs.

"I know AAPC is such a caring and committed organization and the loss in Joplin was so great, so I contacted local chapter officers in Missouri, Kansas, Oklahoma, and Arkansas to see if there was anything their chapters would like to do to help the community of Joplin." She had an overwhelming response. Amy received emails from chapters across the country who wanted to help.

Springfield chapter held a fundraiser and was able to donate over \$1,000 to Convoy of Hope to assist with the relief efforts in Joplin.

May 26, 2011

Dear AAPC Chapter Presidents in Missouri, Kansas, Oklahoma, and Arkansas,

My name is Amy Bishard and I'm president of the Springfield, Mo. AAPC Chapter.

As you all are already aware, the city of Joplin, Mo. was hit by a devastating EF-5 tornado on Sunday, May 22nd. At this time, 125 people have lost their lives and more than 900 are injured. Joplin has a population of about 50,000 and more than 30 percent of the city is completely destroyed (over 8,000 buildings). Thousands of homes were destroyed; one of the city's largest hospitals is in ruins; three schools (including the town's high school – student population 2,000) were demolished; and hundreds of businesses were completely wiped out. This leaves thousands of people homeless, jobless, and completely devastated.

I have been in contact with officers from the Joplin AAPC chapter. As of today, they have only received the status on about 10 of their members. Many have lost their homes, autos, all of their belongings, and even loved ones.

Springfield is about 70 miles east of Joplin; therefore, while we were not directly affected, this definitely hit close to home, as we have many friends and family in Joplin. We are holding a fundraiser in June to donate to the relief efforts in Joplin. We will be collecting requested items of toiletries, clothing, and food. Since the biggest need right now is money, we will be raffling off two Ingenix ICD-10 coding books. Tickets are \$5 each and all proceeds will go directly to Convoy of Hope (www.convoyofhope.org/) to assist with relief efforts. Additionally, our chapter will match up to \$500 of our members' donations.

We are asking other local chapters throughout the four-state area to find a way for their chapter to help the community of Joplin and our fellow coders who have been devastated by this horrible tragedy. Please join our chapter in the relief efforts for Joplin by making a donation to Convoy of Hope and/or the American Red Cross. You can donate directly to either organization, or I will be happy to take the donations.

Let's show Joplin what an awesome and caring organization we are! I will be sharing information about our efforts with our friends from the Joplin chapter, so please let me know if your chapter is able to contribute.

Sincerely,

Amy Bishard

Amy Bishard
Springfield, Mo. AAPC Chapter President

"To help the Joplin chapter, we shared our chapter's Review Class to help their members earn CEUs and to support the Joplin chapter," said Amy. "It should be noted, though, that our contributions were just a small part of what others did."

AAPCCA Gives a Springfield Shout Out

During 2011 Chapter of the Year nominations, AAPC Chapter Association (AAPCCA) Board of Director's Chair **Angela Jordan, CPC**, gave a shout out for Springfield, Mo. In her words:

"The one chapter that really stands out ... to me is the Springfield, Mo. chapter. They have really worked hard to grow their chapter



Michelle received a good response from the new member follow-ups, but she wanted to do more.

in a very competitive two-health system community. I had the opportunity to speak at their seminar last year and they really put on a nice event that pulled in members from the Arkansas and Kansas areas.

However, the thing that really touched me the most was their reaction to the Joplin tornado. They immediately tried to contact the officers of the Joplin chapter to see what they could do, offered to host the exam in Springfield, and volunteer to help with anything they needed. Then, their president, Amy Bishard, sent an email to all of the local chapters in a four-state region to join with them in raising funds for Convoy of Hope ... that is the true essence of what going above and beyond is. To my knowledge, besides their members volunteering in the cleanup effort, they are still lending any support needed to Joplin, as the hospital and doctor's building were destroyed. They truly are a shining example of going above and beyond."

When the AAPCCA 2011 Chair **Melissa Brown, CPC, CPC-I, CFPC, RHIA**, presented the award to Springfield at national conference, she summarized why Springfield deserved the award. It was not only their reaction to a community in crisis that earned them the award, it was much more. In Melissa's speech she stated:

"The 2011 Chapter of the Year ... truly went above and beyond for their chapter members, the medical community, and a community in need. The chapter held additional meetings to help members obtain CEUs and additional exam dates to help members become certified. The chapter held multiple review classes to help members get ready for their exam and offered additional CEUs through an all-day seminar. They developed a chapter newsletter to share important news with their members. They also developed a mission statement and worked to gain new members within their chapter. This is just the beginning of what makes this chapter outstanding ..."

Greetings Guaranteed to Keep 'em Coming Back

The 2011 new member officer, **Michelle Stallings, CPC**, approached her position from the mind set of, "How would I want to be greeted by someone to feel welcome?" Prior to meetings she would stay close to the sign-in sheet or by the door to greet members and visitors as they came in. Michelle, however, was not satisfied with just a greeting; she wanted to do more for new members and made the effort to get to know them. To accomplish this, Michelle would:

- Make packets for new members and visitors that included officer bios, contact info, a calendar of events, their local

chapter website URL, and a personalized welcome card.

- Give a store item to new members, students, and visitors that the chapter had purchased for giveaways.
- Recognize birthdays with a card and some candy.
- Give a congratulatory card and candy to anyone passing the certification exam.
- Follow up after meetings with a phone call, email, or card thanking new members for attending.

Michelle received a good response from the new member follow-ups, but she wanted to do more. She began sending welcome emails to all new members from the notifications she received from the national office once a month. Her goal: "To make people feel welcome before they walk in," Michelle said. "It's much easier to walk into a new place if you already have someone who has reached out."

Converging Hospitals Make a Unique Situation

Springfield has many medical facilities and two major hospitals (CoxHealth and Mercy). Rather than competing against each other, however, the local chapter helps bring everyone together. Amy proudly says, "There is no polarization, despite the fact that many members come from competing medical institutions." They are able to learn and grow from each other because Springfield has "a strong commitment to stay involved with the chapter and encourages others to do the same," Amy said.

Springfield, Mo. chapter is able to meet at least once a month in each others' facilities. **Delynn Perryman, CPC**, said, "The Springfield chapter is very fortunate to have two wonderful facilities to host our meetings ... Springfield is a city rich in many different health care providers and specialties. Our chapter has become a very well-rounded group that represents a wide variety of expertise."

Danne said that "without a doubt," Springfield's variety of members make it a unique chapter. "They are the best!" she said. "I feel so fortunate to be associated with such a wonderful group."

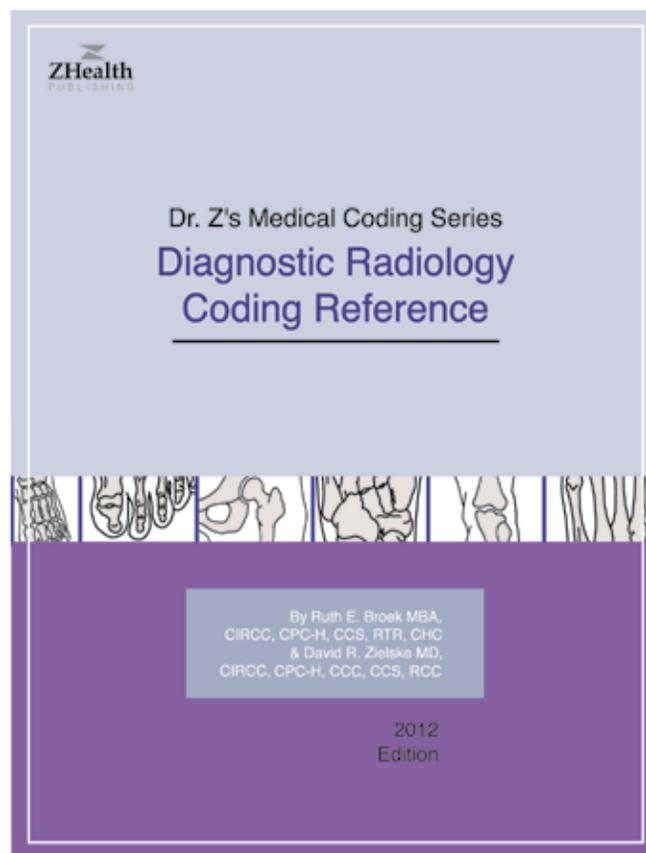
A Chapter with a Mission

Springfield's future goal is to uphold their chapter's mission statement:

"Support members through education and networking opportunities. Our chapter will continue to work to find new ways to meet the needs of our members." 

Michelle A. Dick is executive editor at AAPC.

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Before you code, know its basics.



When it comes to procedure coding, radiology is a world of its own, unlike either evaluation and management (E/M) encounters or surgery. If you are unfamiliar with radiology, here are some basic things to know before you code.

Learn the Language

It is important to understand the terminology used to describe how the patient is placed for the projection of the films to be taken. For example, a report may indicate the patient was in the anteroposterior (AP) position, which describes the front of the patient being closest to the X-ray machine and the X-ray traveling from the front to the back of the patient. Other positioning terms include posteroanterior (PA), lateral, dorsal, supine, prone, decubitus, recumbent, and oblique, etc. Consult a medical dictionary for complete definitions (and possible illustrations) of these positions.

The position of the patient may dictate what procedure code to use, as demonstrated by 71035 *Radiological exam of chest, special views (eg, lateral, decubitus, Bucky studies)*.

Understand Component Coding

The majority of radiological procedure codes have both a professional component and a technical component. The professional

Takeaways:

- Radiology coding is unique and requires a confident understanding of terms to code accurately.
- Attention must be paid to component coding, the number of views, and the various studies used.
- You may need to pull together a number of codes and modifiers to describe the services and procedures performed, but you must pay attention to proper unbundling and medical necessity.

component identifies the service performed by a physician who interprets the film or study, and is identified by appending modifier 26 *Professional component* to the appropriate radiology CPT® code. The technical component includes the services of the technologist and the use of the equipment and films, and is represented with modifier TC *Technical component*. This is known as “component coding.”

If the provider who interprets the film also owns the equipment, a global service is submitted and the professional and technical components are billed together (e.g., the appropriate CPT® code is reported without either modifier 26 or TC appended). The global procedure code is submitted at full fee.

To code correctly, you must know the location where a film was taken and who owns the equipment. For example, a chest X-ray is performed in a freestanding radiology clinic, and a physician who is not employed by the facility interprets the films. In this example, modifier TC is appended to the procedure code because the facility took the films and used its supplies and staff to perform the service. The physician who interprets the X-ray submits a claim with modifier 26 appended for interpreting the film(s). The fee is split, with generally 60 percent of payment going to the technical component and 40 percent for the professional component.

Pay Attention to the Number of Views

Documentation of the number of views taken in an X-ray is crucial because this can affect the selection of the CPT® code. If the number of views is fewer than described by the CPT® code (and another, specific CPT® describing that number of views is not available), modifier 52 *Reduced services* would be appended to indicate the service provided was less than that described by the code.

For example, a provider orders an X-ray of the left wrist, but only wants one view taken. The minimum number of views for a



To code correctly, you must know the location where a film was taken and who owns the equipment.

wrist X-ray is two (73100 *Radiologic examination, wrist; 2 views*). In this case, you would claim 73100-52 to correctly report one view of the wrist. No additional modifiers would be needed unless the service represented either the professional or technical component.

Expand Your Knowledge

Although “radiology” has historically been used to refer to radiographic films, the term now encompasses all aspects of medical imaging, including ultrasound, nuclear medicine, computerized tomography, and magnetic resonance imaging.

Common practices of radiology include:

- Diagnostic radiology describes diagnostic imaging:
 - Radiographic examination (X-ray)
 - Computed axial tomography (CT)
 - Magnetic resonance imaging (MRI)
 - Magnetic resonance angiography (MRA)
 - Diagnostic ultrasound uses high frequency sound waves to image structures
 - A mode is one dimensional amplitude of sound return (echo)
 - M mode is one dimensional with movement (motion)
 - B scan is a two dimensional display of movement of tissue and organs (brightness)
- Ultrasound guidance is used in biopsies, aspirations, or injections to assist the radiologist in determining the exact location to place needles, as well as the best route to the site.
- Nuclear medicine uses the placement of radionuclides within the body to diagnose disease and monitor emissions from the radioactive elements. A radioactive isotope is injected and imaged to observe the function of organ. An example of this would be hepatobiliary system imaging to determine the function of the gallbladder.
- Radiation oncology is used to destroy tumors. Steps or stages of treatment are:
 - Clinical treatment planning determines treatment dosage, time, choice of treatment and size, and number of treatment ports.
 - Simulation determines treatment areas and placement of ports.

- Radiation treatment is the delivery of the radiation.
- Clinical brachytherapy is the placement of radioactive material directly into or surrounding the site of a tumor.

To completely describe the service performed for interventional radiology procedures, codes from radiology and other sections of the CPT® codebook are necessary. Interventional radiologists perform both the radiologic and surgical portions of a procedure.

Documentation of the interventional services must be carefully read to ensure accurate coding and to capture all services performed. Documentation could include procedures for injected materials, placed catheters or guide wires, and imaging. Understanding what is narrated in a radiologic or operative report is very important. If an unfamiliar term is used, query the physician to gain comprehensive knowledge.

Put It All Together

When a surgeon performs the surgical portion of a procedure, the radiologist reports the imaging and/or the other service. For example, the interventional radiologist performs angioplasty; access is gained through a puncture site and imaging techniques are used to guide a catheter into an artery or vein. Contrast material is injected and an angiogram is taken to identify the site of the blockage. A balloon catheter or stent may be used for definitive treatment of the blockage. Further imaging is performed after the treatment to verify the blockage no longer exists.

In this example, the radiologist could potentially have procedure codes for the catheterization, guide wire, balloon catheter or stent, contrast, and imaging. National Correct Coding Initiative (NCCI) edits must be used to ensure procedures and services considered bundled into another service are not separately reported.

Although there are differences between radiology, E/M, and surgical coding, the knowledge gained from learning each is invaluable. Don't be afraid to venture into the unknown of radiology coding. 



Brenda Edwards, CPC, CPMA, CPC-I, CEMC, entered the coding and billing profession 25 years ago. Her responsibilities at Kansas Medical Mutual Insurance Company (KaMMCO) include chart auditing, coding and compliance education, and contributing articles to the company website and publication. Brenda is an AAPC-approved PMCC instructor and an ICD-10 trainer. She is a frequent speaker for local chapters in Kansas and Missouri, and has presented at AAPC regional conferences and workshops. Brenda is on the AAPC Chapter Association Board of Directors.

Let Documentation Drive Your Coding

Here's what to do when your provider's documentation takes a back seat.

If it isn't documented, it wasn't done. That's the golden rule of coding. As we've all been told again and again, inaccurate documentation can lead to improper payments, non-compliance with government and insurance regulations, and audit risks. Unfortunately, the demands of a busy patient schedule, incoming calls and emails, and managing a staff and a practice mean that, for some providers, documentation sometimes takes a back seat.

Coders can help improve documentation, and have a responsibility to provide physicians with constructive feedback on areas of improvement. It is equally important for staff members to research and provide their physicians with solid information from authoritative sources. Here are some key points to remember when advising physicians on the importance of accurate and complete documentation.

Reports Don't Need to Be Lengthy to Be Complete

For each patient service, there are minimum requirements of what must be included in the medical record. For example, in most cases an evaluation and management (E/M) must have history of present illness (HPI), examination, and medical decision making (MDM) components (see your CPT® codebook for exceptions).

Radiology reports must document technique as well as findings of the study. For example, consider an ultrasound of the thyroid with a duplex study: The record should include the technique for the ultrasound and all findings, as well as a separate area discussing inflow and outflow, vascular structure, and any relevant findings. You don't need the equivalent of two standalone reports to be complete. Omit just a few words, however, and coding the additional study becomes questionable.

Takeaways:

- As a coder, you can improve documentation by providing your physicians with feedback.
- Documentation doesn't need to be long, but it must be complete and to the point.
- Document same-day procedures with special care.

Documentation Must Be Relevant

I once provided E/M documentation training to a group of physicians who were reluctant to receive it. They felt they were doing just fine. Following the training, I began to receive reports including lines in the examination portion such as, "The patient has a round head, two eyes, two ears on opposing sides of the round head," etc. Not only did the doctors not improve their documentation to support a higher level of E/M service, they received a letter from a large insurance carrier stating they were doing an extended audit of their E/M services.

Extraneous documentation can sometimes do more harm than good. It can raise a red flag with the carriers that your provider is trying to upcode by doing more work than is necessary for the service. My advice to physicians is stick to what's relevant and be thorough.

Documentation Must Support Specific Coding

CPT® instructs you to select the code that accurately identifies the service or procedure performed. You should not select a CPT® code that merely approximates the service provided. Documentation must support the code you select. Implied meanings and assuming something is done when it is not written in the record is where the trouble begins.

Let's look at one example of a common service in radiology:

Computed tomography angiography (CTA) is used to evaluate a patient's blood

vessels and can detect stenosis and aneurysm (among other things) in the vascular system. According to the American Medical Association (AMA), CTA requires 3-D angiographic rendering. Acceptable terms used to describe 3-D postprocessing include maximum intensity projection (MIP), shaded surface rendering, and volume rendering, along with the term 3-D.

A typical chest CTA report may read:

During the intravenous administration of 100 cc of contrast material, spiral scans of vascular structure obtained from the lung apices through the adrenal glands were performed.

The report may even go on to state, "reformatted reconstructions were obtained."

Clinically, we know the doctor performed a CTA. He or she is reviewing the vascular structure. The history likely supports this, as well; however, without one of the terms above (MIP, shaded surface rendering, etc.), coding this as a CTA would be inappropriate. If this report went for medical review, the service would not be considered a CTA. If this had been submitted as a CTA, the result would be returned monies (if already paid), a broader request for records and audits, and potential reporting to the authorities as fraud.

The inclusion of one of the terms above changes the whole thing. Let's look at this same example, but now the additional line states, "*3-D reformatted reconstructions were obtained.*" The addition of two letters changes everything. This documentation now supports a CTA; and, if the records were requested for review, everyone could rest easier knowing their documentation is up to par.

Implied meanings and assuming something is done when it is not written in the record is where the trouble begins.

Document Same-day Procedure, E/M with Special Care

Let's look at another common problem with documentation that can raise red flags: Procedures provided the same day as an E/M service.

For example, a patient comes in for a scheduled knee joint injection for pain and arthritis. The service includes evaluating the patient to ensure he is able to receive the service. While he is there, the patient mentions he has been having some mild headaches and pressure over the past week. The doctor determines the patient has sinusitis and suggests over-the-counter decongestants and nasal saline washes.

When reporting an additional study, the documentation must pass what is referred to as the "highlighter test." When all the elements have been highlighted to support the initial service, what's left to support the additional service? In this scenario the documentation may read something like this:

Established patient with cc knee pain, patient with known osteoarthritis uncontrolled with OTC pain-relievers, presents today for cortisone injection. Patient also complains today of mild headache and facial pressure over the past week.

HEENT exam shows inflammation of the maxillary sinus with some minor congestion. Moderate swelling and stiffness of the left knee compared to right. Some pain with rotation.

Patient informed of risks and benefits and wishes to proceed. Knee prepped with alcohol and 3 cc of hydrocortisone injected into the intra-articular left knee space. Patient tolerated procedure well. Advised to proceed to ER if any adverse reactions occur after leaving the office. Instructed OTC decongestant and saline nasal spray for sinusitis.



Let's deconstruct this record and see what services it supports. Start by highlighting the knee injection. We've got the first line directly related to why the patient was scheduled for the appointment. A limited exam of the affected area is documented in the following paragraph. The remainder of the note talks about the procedure performed.

The injection is supported in this report. After we highlight all those lines, what's left?

Patient also complains today of mild headache and facial pressure over the past week. HEENT exam shows inflammation of the maxillary sinus with some minor congestion. Instructed OTC decongestant and saline nasal spray for sinusitis.

We've covered history, exam, and MDM with a diagnosis of sinusitis. This is enough for a separately identified E/M service (limited, yes, but a visit can be billed, nonetheless). Just be sure to use modifier 25 *Significant, separately identifiable evaluation and*

management service by the same physician on the same day of the procedure or other service when billing an E/M on the same date as a procedure.

CMS transmittal 954 (*MLN Matters*® MM5025, change request (CR) 5025, May 19, 2006) states specifically that you should apply modifier 25 only for "a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work for the service."

It is important to remember that the only proof of what was performed is what is written in the documentation. Without getting it in writing, it is just a memory of the physician, and nothing more. ☐

Robyn Margani, CPC, is the director of coding operations for a large multi-specialty revenue cycle management company based in Pennsylvania. Robyn plays a key role in the strategy, planning, development, implementation, and maintenance of coding processes, policies, and education to ensure compliance and to maximize physician reimbursement.

Take Advantage of an Unexpected Delay

ICD-10 implementation gets one-year postponement.

Unexpected delays can be advantageous, allowing additional time to re-examine strategies and adapt to a new situation. Consider the football coach who is suddenly provided with an unanticipated “time out.” An extra minute or two provides valuable time to reassess the immediate plan, perhaps affecting a more optimal outcome. As health care organizations continue to prepare for ICD-10, it’s important to look at the long-term vision and commitment to the implementation effort, which should include a plan for addressing change.

The rush to meet the previous deadline of Oct. 1, 2013 had some organizations on a tight implementation schedule. With the focus on organizational awareness and development of an implementation timeline, it was often difficult to know where and how to begin. The “blessing in disguise” of the proposed implementation delay to Oct. 1, 2014 may very well be the additional time to conduct quality systems inventory and appropriate training at a more comfortable and affordable pace.

Take a Deep Breath

The proposed one-year delay to implement ICD-10 offers a bit of breathing room for physicians who are still working on other deadlines such as 5010 and electronic health record (EHR) “meaningful use” requirements. The deadline for 5010 implementation was Jan. 1, 2012, but the Centers for Medicare & Medicaid Services (CMS) recently extended the enforcement deadline to June 30, 2012. The original ICD-10 implementation timeline of 2013 was conceived before meaningful use was proposed. Electronic physician documentation is expected to be a core component of Stage 2 and 3 meaningful use objectives. There are some who wanted ICD-10 deferred until after meaningful use Stage 3, which would have allowed physicians more time needed to boost clinical documentation on the front end.

With a little extra time added to our implementation schedule, training efforts can be redesigned so the work on the front end (physician documentation) meshes effectively with the work on the back end (ICD-10 coding).

Strengthen Your Game Plan

Just as football coaches do when presented with an unexpected game delay, it’s important for those involved with ICD-10 implementation and training to use the additional time to their advantage. Physicians and other health care entities should embrace the bonus months to expand and enhance training efforts. Be diligent and stay on track with your game plan; the transition to ICD-10 will continue to be a complex and extensive endeavor.

If you haven’t already done so, it’s time to conduct a system-wide impact assessment. Identify the effects of the new code set on every department in your organization. Ask yourself:

- What is the expected impact on physician documentation processes and workflow?
- Is physician clinical documentation up to par and will it support the increased specificity?
- Do we have sufficient resources to train physicians on the enhanced documentation requirements for ICD-10?

Coding managers and trainers can conduct coder training and skill set training at a slightly more comfortable pace. Use the additional time to “train the trainers,” who will become your organizational super users. Perhaps now, everyone will become more comfortable with ICD-10, the guidelines surrounding coding and reporting, and the overall application of the code set. Hopefully, the additional training days and months will enhance accuracy and overall productivity.

With the impending implementation delay, you’ll need to revisit and adjust your internal timeline. Determine your new timeframe for training, review payer contracts, verify data conversion of ICD-9 to ICD-10 information (such as EHR problem lists), and redesign electronic or paper forms and vendor training schedules. It’s also a good time to re-examine the existing budget and perhaps establish a line of credit. Providers were encouraged to consider doing this prior to the 5010 transition; however, many did not and were caught off guard by unexpected payment delays. The transition to ICD-10 will inevitably affect cash flow. Some financial institutions have a wait-

Perhaps now, everyone will become more comfortable with ICD-10, the guidelines surrounding coding and reporting, and the overall application of the code set.



Coder's Roadmap to ICD-10

Below is a full curriculum to prepare coders for the Oct. 1, 2014 implementation of ICD-10. All AAPC members and industry coders are strongly encouraged to consider all steps in the plan as each one provides the foundation for the next.

ICD-10 TIMELINE



ing period before line of credit funds are available, so now's the time to consider this option.

Look to Resources for Help

AAPC will provide guidance to members as more details of the proposed Oct. 1, 2014 implementation delay are released. AAPC's "Coder's Roadmap to ICD-10" is an excellent tool and is available at <http://static.aapc.com/ppdf/AAPCICD10RoadmapFlier97.pdf>.

Watch for revisions in the timeline and use the additional months wisely. By continuing with your implementation efforts, you'll enjoy a smoother, less frenzied transition.



Jeri Leong, RN, CPC, CPC-H, CPMA, is president and CEO of Healthcare Coding Consultants of Hawaii, a company which provides coding support and education for physicians and health care organizations. She is the founder and past president of the Honolulu local chapter. In 1996, Jeri was selected as a member of the AAPC's National Advisory Board, and served as NAB president from 2003 to 2005. She recently completed a term on the AAPC Chapter Association (AAPC-CA) Board of Directors and is also an AAPC-approved ICD-10 trainer.



A&P Quiz

By Rhonda Buckholtz, CPC, CPMA, CPC-I

Think You Know A&P? Let's See ...

Melanomas kill an estimated 8,700 people each year. Primary malignant melanomas may be classified into various histologic types, including lentigo malignant melanoma, which usually arises on chronically sun-exposed skin of older individuals; superficial spreading malignant melanoma; nodular malignant melanoma; acral lentiginous melanomas; and malignant melanomas on mucous membranes. Clinical features of pigmented lesions suspicious for melanoma are an irregular notched border where the pigment appears to be leaking into the normal surrounding skin or a topography that may be irregular, such as partly raised and partly flat.

Where do acral lentiginous melanomas usually arise?

- A. On palms, soles, and nail beds
- B. On chronically sun-exposed skin of older individuals
- C. On soles of feet
- D. On the trunk of the body

The answer to this question is located somewhere in this issue!

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

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By Laurette Pitman, RN, CPC-H, CGIC, CCS

Align Coding with Video-assisted Thoracic Surgery Advances

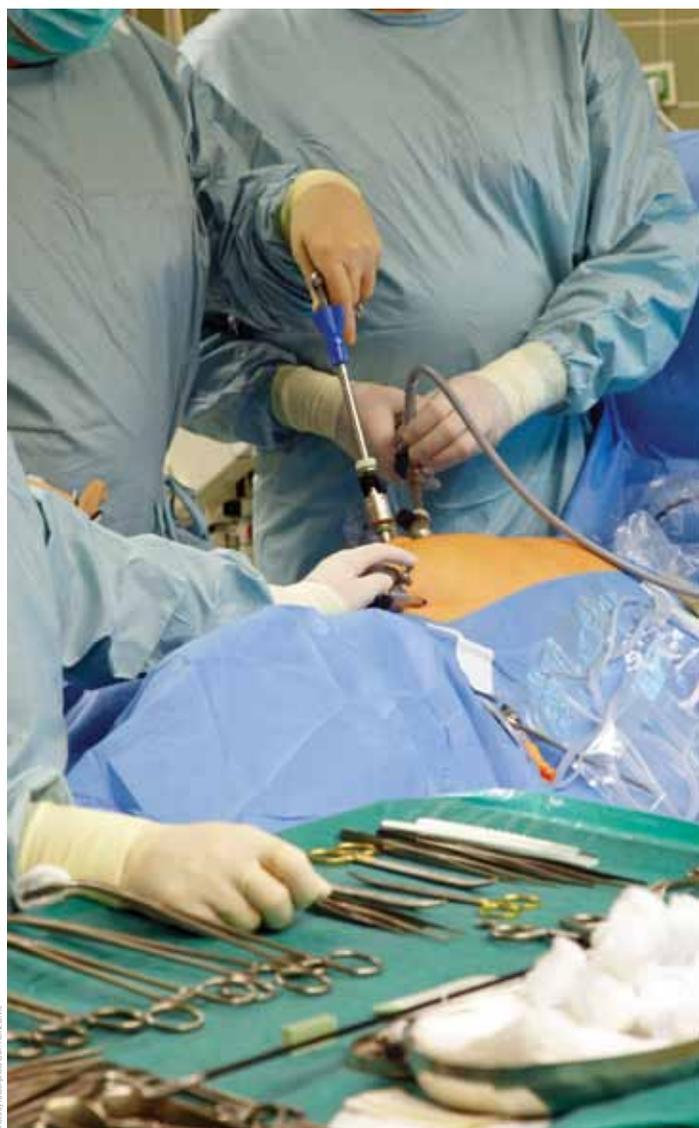
2012 introduces new codes for both diagnostic and surgical VATS.

Due to advances in surgical procedures, video-assisted thoracoscopic surgery (VATS) has an increasing role in the diagnosis and treatment of a wide variety of thoracic disorders that previously required sternotomy or open thoracotomy. Patients who undergo this procedure have the advantages of less postoperative pain, fewer surgical complications, a shortened hospital stay, and reduced costs.

The procedure is performed with the use of small fiber optic cameras that allow the surgeon to look inside the chest, usually via a monitor. Similar to a laparoscopic procedure, small incisions are made in the chest allowing the surgeon to introduce the thoracoscope and other small instruments, which may be used for cutting, stitching, or stapling. Following the VATS, a chest tube may be left in the operative pleural cavity for drainage and/or lung re-expansion.

Multiple procedures can be performed using VATS to treat an assortment of disorders. For example:

- | | |
|-----------------------------|---|
| Biopsies | • Mediastinal masses |
| • Lung nodules | • Pleura |
| • Interstitial lung disease | Drainage |
| • Mediastinal lymph nodes | • Pleural effusion |
| • Mediastinal masses | • Empyema |
| • Pleural abnormalities | • Lung abscess |
| • Chest wall masses | Treatment of: |
| • Esophageal tumors | • Hyperhidrosis |
| Excision | • Reflex sympathetic dystrophy |
| • Lung nodules | • Pneumothorax |
| • Lung biopsies | • Limited stage lung cancer in high-risk patients |
| • Apical blebs | |
| • Mediastinal lymph nodes | |



Multiple procedures can be performed using VATS to treat an assortment of disorders.

Pay special attention to the parenthetical note following 32668, which identifies allowable primary procedure codes.

CPT® codes for reporting VATS procedures are found in the 32601-32609 series for diagnostic procedures, and 32650-32674 for surgical procedures. New codes were introduced this year for both diagnostic and surgical VATS procedures.

Diagnostic VATS

CPT® codes 32607 *Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral*, 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral*, and 32609 *Thoracoscopy; with biopsy(ies) of pleura* identify thoracoscopic biopsy procedures. A diagnostic biopsy or biopsies of lung infiltrate—whether by wedge or incisional technique—is reported using 32607. If the thoracoscopic biopsy is performed on a lung nodule or mass (again, either wedge or incisional), select 32608. Both 32607 and 32608 are unilateral codes, reported only once per lung; procedures performed on both lungs require the use of modifier 50 *Bilateral procedure*.

Clinical Coding Example: A 75-year-old male smoker presents with a growing pulmonary nodule in the left lung.

Description of Procedure: A small incision is made in the initial trocar site on the left chest and the pleural cavity is entered. The thoracoscope is advanced into the pleural cavity. Visual exploration is performed. Additional trocar incisions are made for access ports. Adhesions between the lung and chest wall are freed. The chest and lung are explored. The pulmonary nodule is identified and a stapled wedge biopsy is obtained. The biopsied lung tissue is placed in a sterile bag and removed. Hemostasis is performed with endoscopic electrocautery. A chest tube is inserted through a separate interspace incision. All trocar incisions are assessed for hemostasis. Sponge and needle count are accurate. Each incision is closed with multiple layers of suture for muscle and the skin re-approximated with a subcuticular stitch. The biopsy specimen is sent for pathological analysis.

CPT® code assignment for this example is 32608-LT. Modifier LT *Left side* is an anatomic modifier that indicates the area or part of the body on which the procedure was performed.

For patients with exudative pleural effusions, pleural thickening, or pleural tumors, a thoracoscopic biopsy may be performed to obtain a definitive diagnosis. This procedure is reported with 32609, one time only, even if multiple biopsies are obtained. Per the Medicare Physician Fee Schedule Database (MPFSDB), modifier 50 does not apply to this code.

Surgical VATS

Surgical VATS codes include pleurodesis, resections, lobectomy, segmentectomy, pneumonectomy, and lung volume reduction. Medicare has designated these as inpatient-only procedures (status indicator C); you would not expect to see these procedures in the outpatient setting.

Pleurodesis is accomplished to artificially obliterate the pleural space and prevent the recurrence of pneumothorax or pleural effusions. This procedure can be done either chemically or mechanically. In a chemical pleurodesis, a substance such as bleomycin, tetracycline, povidone iodine, or a talc slurry is introduced into the pleural space. This results in an irritation between the parietal and visceral layers of the pleura and closes off the pleural space. In the mechanical method, the pleura are irritated, typically with a piece of rolled-up Marlex mesh mounted at the end of an endoscopic grasper. Performed chemically or mechanically, the procedure is reported with 32650 *Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical)*.

CPT® codes 32666-32668 describe diagnostic and therapeutic wedge resections. A wedge resection involves the surgical removal of a wedge-shaped portion of tissue

from one or both lungs, and is usually performed for the diagnosis or treatment of small lung nodules. CPT® 32666 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral* is reported for an initial unilateral therapeutic wedge resection of a mass or nodule. Modifier 50 is appended for bilateral procedures. Add-on code +32667 *Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)* describes additional thoracoscopic therapeutic wedge resections performed during the same operative session.

When a VATS diagnostic wedge resection is followed by an anatomic lung resection, add-on code +32668 *Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)* is reported. Pay special attention to the parenthetical note following 32668, which identifies allowable primary procedure codes.

Clinical Coding Example: A 68-year-old female smoker is found to have a growing pulmonary nodule in the lower lobe of her left lung. Diagnostic tests do not indicate metastatic disease. Pulmonary function is normal. Plan is for resection by VATS.

Description of Procedure: Trocar sites are identified. A small incision is made and the initial trocar is inserted followed by the thoracoscope. The thoracoscope is advanced into the pleural cavity and initial visual exploration is performed. Additional trocar incisions are made. Access ports are placed for the passage of instruments. Adhesions between the lung and chest wall are freed. The chest and lung are explored via thoracoscope. The target pulmonary nodule is located with mobilization of the lung as necessary for exposure. Using an endoscopic tissue stapler, a wedge resection of the nodule is performed removing the nodule, along with a 1-2 cm margin of normal lung tissue. The specimen prior to removal is placed in a sterile bag and sent for frozen section. Hemostasis is secured with electrocautery and staple lines are checked.

Pay careful attention to physician documentation to differentiate the procedures.

Frozen section results are positive for carcinoma. It is decided to proceed with VATS lobectomy.

The lung is retracted superiorly and the inferior pulmonary ligament is divided with electrocautery. The mediastinal pleura is dissected away from the inferior pulmonary vein. Care is taken to dissect the inferior pulmonary vein from the superior pulmonary vein. The endoscopic vascular stapler is then used to divide the inferior pulmonary vein. Following this, the lower lobe is retracted inferiorly and dissection is performed in the fissure to separate the upper and lower lobes. The pulmonary artery is identified and freed. The arterial branches to the lower lobe are divided with the endoscopic vascular stapler. The lower lobe bronchus is then identified and divided utilizing the endoscopic tissue stapler. The resected lobe is endoscopically placed in a sterile bag and removed from the chest cavity via an accessory incision.

All staple lines are assessed for hemostasis and air leakage. The lung is deflated and chest cavity irrigated. A chest tube is inserted through a separate interspace incision. The anesthetist is instructed to inflate the operative lung so that re-expansion can be visually confirmed. The thoracoscope is removed. Each trocar incision is closed in multiple layers and dressings applied.

CPT® code assignment in this example is 32663 *Thoracoscopy, surgical; with lobectomy (single lobe)*, along with add-on code +32668 *Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)*. Modifier LT is appended to indicate the procedure was performed on the left lung.

Codes for lobectomy, segmentectomy, and pneumonectomy are assigned dependent on the amount of tissue or anatomic area removed. VATS lobectomy is a surgical procedure that removes one lobe of the lung that contains cancerous cells. As in a lobectomy performed via thoracotomy, the VATS procedure dissects, ligates, and divides the pulmonary artery, pulmonary vein, and bron-

chus to the involved pulmonary lobe. Typically, endoscopic stapling devices are used to accomplish the ligation and division of the vessels and bronchus. The surgical specimen is placed into a watertight bag and removed from the chest.

CPT® 32663 *Thoracoscopy, surgical; with lobectomy (single lobe)* is reported for removal of a single lobe and 32670 *Thoracoscopy, surgical; with removal of 2 lobes (bilobectomy)* is reported for removal of two lobes (bilobectomy).

Segmentectomy involves the removal of a larger portion of the lung lobe than a wedge resection, but does not remove the whole lobe. Pay careful attention to physician documentation to differentiate the procedures. Report 32669 *Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)* for removal of a single lung segment.

Removal of an entire lung is called pneumonectomy. It is most commonly performed for cancer of the lung that cannot be treated by removal of a smaller portion. VATS pneumonectomies are rarely indicated because most tumors needing a pneumonectomy are either T3 or large hilar tumors (*Mastery of Cardiothoracic Surgery*, Larry R. Kaiser, Irving L. Kron, Thomas L. Spray, October 2006).

When performed, VATS pneumonectomies are similar to open pneumonectomy. The pulmonary vein, pulmonary artery, and main stem bronchus are dissected and divided sequentially using endoscopic stapling devices. For VATS pneumonectomy, report 32671 *Thoracoscopy, surgical; with removal of lung (pneumonectomy)*.

Lung volume reduction surgery (LVRS) is indicated in patients with moderate to severe emphysema. The purpose of the surgery is to remove parts of the lung that do not work, allowing the remaining lung tissue to work more effectively. During VATS

LVRS, 30-40 percent of each upper lobe may be removed, allowing expansion of the remaining lung. By reducing the lung size, airways are opened, making breathing easier.

In the VATS procedure, endoscopic stapling is used to cut out diseased lung tissue from healthy lung tissue. Report 32672 *Thoracoscopy, surgical; with resection-plectation for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed for a VATS unilateral lung volume reduction procedure*. Append modifier 50 if the procedure is performed on both lungs. Code 32672 is also inclusive of any pleural procedure performed during the LVRS.

Note: A national coverage determination (NCD) for the LVRS procedure, published by the Centers for Medicare & Medicaid Services (CMS), includes specific criteria that must be satisfied for the procedure to be covered for the Medicare beneficiary (*Medicare National Coverage Determinations Manual*, chapter 1, part 4: 240.1).

As always, thorough and accurate physician documentation is the key to correct CPT® code assignment. Carefully read the operative note and review all CPT® instructional notes to aid in accurate code assignment, substantiation of the billed procedure, and proper reimbursement. ■



Laurette Pitman, RN, CPC-H, CGIC, CCS, is a senior outpatient consultant for Spi Healthcare. She has over 30 years' experience in the health care field including ED and OR nursing, coding, and DRG and APC auditing. For more information, please reference

www.spihealthcare.com or contact Laurette at laurette.pitman@spihealthcare.com.

Appeal Claims Strategically to Capture Revenue You Deserve

Let under-utilized appeals systems work for your practice.

Sometimes, even if you do everything right, you may end up with denied claims. Rather than throw up your hands and walk away, you should appeal. Yes, it will mean extra work, but the results are worth it: Most of the offices I've worked with have increased their revenue by at least 30 percent through strategic appeals. Here are seven steps to get you started.

1. Investigate Every Denial

If the insurer denies a claim, you must find out why and follow up to correct problems or collect payment if the denial is in error. Double-check everything about the claim to be sure you have grounds for appeal. Do not just re-file an unamended claim, hoping for payment the second time around.

For instance, if you are coding a surgery, review the “body” of the operative report to be sure all listed procedures actually were performed. Check modifier use. Maybe you missed a necessary modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.*



Takeaways:

- Appealing a denied claim is worthwhile if you're strategic.
- Preparation including knowledge of the claim, your agreements with the payer, and the various avenues of appeal is essential for success.
- Understand the levels of appeals to assure you are prepared for the argument.

or 59 *Distinct procedural service*? If the insurer denies the claim for medical necessity, check to be sure the service was documented appropriately. Regardless of what the doctor does or how valid the service, you are sure to get a denial if the details are not documented sufficiently to support the claim.

If the insurer's denial is unwarranted, or you are able to legitimately amend the claim to gain payment, it's time to roll up your sleeves and ready yourself for an appeal.

2. Know Your Payers' Appeal Process

Be sure you understand your rights to appeal. Most fully-funded plans have a designated external appeals process. Appeals may be more difficult with self-funded plans; you may wish to seek the advice of an attorney. Determining if plans are self-funded or fully funded will help you prepare for appeals before you have to pursue them.

Know the type of problems and issues your state's external appeal programs address, and whether appeal programs other than the state's external appeal program and the insurer's internal appeal programs are available to you.

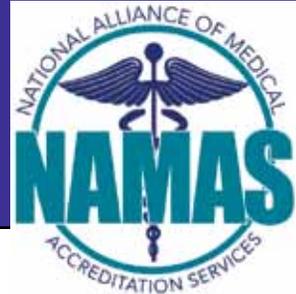
3. Explain Yourself, Then Mark Your Calendar

Prepare a letter to the payer that explains exactly why you are appealing. If you're unable to state in straightforward terms why you deserve payment, don't expect to get it.

Be sure to submit appeals in the allowable time frame. This usually is 180 days. The time may be less if you are contracted. If you are contracted, review your rights; you may have given up your appeal right by being in network.

Tip: The appeals process for Medicare payers is stipulated by Centers for Medicare & Medicaid Services (CMS) guidelines. See the accompanying article, “Know the Medicare Appeals Process,” for more information.

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Before pursuing an appeal, assess the amount of the claim and determine if it is worth the fees.

4. Send Appeals Certified

When submitting an internal appeal, send it via certified mail. You need to track that the insurer received the appeal. If you can't track it, you have no proof it was ever sent.

If you did your homework, you know exactly how long the insurer has to respond to your appeal. If you do not have a response by the allowed time, file a complaint with your state insurance department. The state may ask for proof you sent the appeal (which is where your certified mail receipt comes in).

5. Be Wary of Internal Appeals

The insurer is likely to first pursue an internal appeals process. Some insurance companies require two internal appeals, while others require only one internal appeal.

Before you pursue an internal appeal, make sure it is mandatory. If it isn't, and you choose to file internally with the insurer, one of two things could happen that are not to your benefit:

1. The insurance company sends your appeal to an outside vendor for review. Such reviews are supposed to be independent, but often are not. Appeal decisions of this type can be binding, or can be used against you in later appeals.
2. While you are pursuing an optional appeal, you may be missing out on your time to submit to the state. Most external appeal to the state must be sent within a certain time frame from your final adverse appeal determination letter. If you miss a deadline, you will lose your right to appeal.

Bottom line: Only agree to mandatory internal appeals. Do not accept optional appeals.

6. Direct External Appeals Appropriately

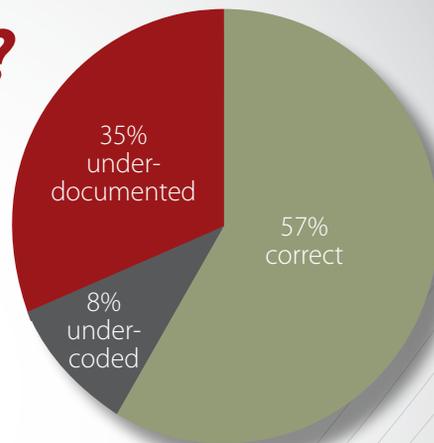
If you exhaust the internal appeals process without results, you must decide where external appeals need to be sent. For example, New Jersey has two appeal systems: one for experimental/medical necessity and another for incorrect payments. You also need to find out what your state requires you to send to them to process an external appeal.

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By Heather M. Shand, CMAA, CBCS, CMB, and G.J. Verhovshek, MA, CPC

Know the Medicare Appeals Process

After an initial claim determination, providers, participating physicians, and other suppliers have the right to appeal, which may progress through as many as five levels. All appeal requests must be made in writing and must contain specific information (such as beneficiary name, dates of service, and other details), as detailed in the Centers for Medicare & Medicaid Services (CMS) publication "The Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers" (www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf).

First Level: Redetermination

A redetermination is an examination of a claim made by fiscal intermediary (FI), carrier, or Medicare administrative contractor (MAC) personnel; these are not the same people who made the initial determination. The appellant (the person filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. No monetary threshold is applied to first-level appeals. The FI has 60 days from the date of receipt to issue a redetermination. If a provider disagrees with the FI's redetermination the provider may seek the second level of appeal.

Second Level: Reconsideration by a Qualified Independent Contractor

Second-level appeals, or reconsiderations, are made to a qualified independent contractor (QIC). No monetary threshold is applied to second-level appeals. The provider must file reconsiderations within 180 days of receipt of the FI's redetermination.

All supporting documentation, such as the initial demand letter and any evidence supporting the provider's claim and the FI's redetermination should be submitted with the reconsideration request. Any documentation not submitted prior to the issuance of the reconsideration decision may be excluded from subsequent levels of appeal. Additional evidence or documentation may be admitted only in subsequent levels of appeal upon a showing of "good cause." Where the appeal is a matter of medical necessity, a QIC is required to have an independent panel of physicians or other appropriate health care professionals review the claim.

The QIC has 60 days from the date of receipt to issue reconsideration. If a provider disagrees with the results of the QIC's reconsideration, the provider may seek the third level of appeal. If the QIC does not finish its reconsideration during the 60-day time frame, the provider has the option to accelerate to the

next level of appeal by filing directly with the administrative law judge (ALJ).

Third Level: Administrative Law Judge Hearing

ALJ hearings are available if the amount in controversy totals at least \$130. A request for an ALJ hearing must be filed within 60 days after receipt of the QIC reconsideration decision. The request also must be forwarded to the individuals who participated in the QIC panel.

Specific reasons why the defense disagrees with the level 1 and 2 findings, cogent arguments, and expert witness testimony at this level can be helpful because the ALJ will often seek clarification from the expert why the provider documented a certain way, or may ask the expert to explain why the defense disagrees with previous appeals.

ALJ hearing decisions must be issued within 90 days after receipt of the hearing request. If the ALJ hearing decision is not issued within the applicable time frame, the provider may request to the ALJ that their approval move forward to the fourth level of appeal. If a provider disagrees with the result of the ALJ hearing, the provider may seek the fourth level of appeal.

Fourth Level: Medicare Appeals Council Review

Fourth level appeals are made to the Medicare Appeals Council. There is no monetary threshold, although all claims must be at least \$130.

A request for a Medicare Appeals Council review must be filed within 60 days of receipt of the ALJ hearing decision. A Medicare Appeals Council decision must be issued within 90 days of receipt of the request for review. If a Medicare Appeals Council decision is not issued within the applicable time frame, a provider may request for their appeal to move forward to the fifth level of appeal. If a provider disagrees with the results of the Medicare Appeals Council, the provider may seek the fifth level of appeal.

Fifth Level: Judicial Review in U.S. District Court

Judicial review in U.S. District Court is available only if the amount remaining in controversy totals at least \$1,260. The request for judicial review must be filed within 60 days of receipt of the Medicare Appeals Court decision. There is no time frame for the judicial decision.



For information regarding your state external appeals, go to your states' departments of banking and insurance websites (or, call them). Most states require you to complete a form, and some states charge fees of \$25-\$250. If the appeal is in your favor, they usually return the money.

Note: There are avenues to collect incorrect payments/underpayments. You can use Maximus if your state has that program. Most states also have a complaint department you can use for these types of issues, which are outside of the normal appeal systems.

7. Be Strategic

Before pursuing an appeal, assess the amount of the claim and determine if it is worth the fees. Ask yourself: Does the amount of the claim warrant the fees you might lose? For instance, if the claim is \$25, you most likely won't risk \$100 in fees to submit it. Keep in mind the insurance company also has to pay for external appeals, so this can be a bargaining chip.

Appeal systems are underutilized. The appeals systems can work for your practice and can increase your revenue. You will have to put time into this process, but the rewards are great. Keep in mind that all external appeals are paper reviews, not oral reviews. You need to make sure you are articulating your argument in an orderly, rational, and reasoned manner. If you have documented correctly and can articulate your agreement on paper, there is no reason why you cannot capture your lost revenue. 

Heather Shand, CMAA, CBCS, CMB, is CEO of N&D Consulting, LLC, and Smart Healthcare Solutions. N&D is a consulting, billing, and collection management firm for all types of practices, specializing in revenue management. Heather has served on the advisory board for Lincoln Technical Institute. Prior to starting N&D Consulting, Heather worked for a multi-disciplinary practice for several years.

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

Keep in Step with SEP and MEP

CPT® 2012 revises intraoperative neurophysiologic monitoring code usage for surgery.

Use of intraoperative neurophysiologic monitoring (IONM) has increased over the last decade due to evidence of its role in reducing or preventing the incidence of paralysis or paraparesis in certain types of surgeries. Changes to CPT® 2012 affect codes used to bill monitoring for surgeries involving motor evoked potentials (MEP) and somatosensory evoked potentials (SEP).

Turn to 95938, 95939 for Combined Limb Studies

Since January 2012, four-limb SEP tests are reported using 95938 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs* for short-latency SEP studies; code 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* is now used for central MEP studies.

The addition of 95938 and 95939 to CPT® 2012 reflects that all four limbs are tested together in virtually all cases. Per CPT® parenthetical instructions, do not report 95925 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs* with 95926 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs*, or 95928 *Central motor evoked potential study (transcranial motor stimulation); upper limbs* with 95929 *Central motor evoked potential study (transcranial motor stimulation); lower limbs* to describe four limb studies.

Although 95925-95926 and 95928-95929 are still active, they do not properly describe four-limb studies, and should be used to indicate studies of only the upper or lower limbs, as appropriate.

Codes 95938 and 95939 may be applied in

Takeaways:

- Use of IONM has increased to help reduce or prevent paralysis or paraparesis in certain types of surgeries.
- Learn the changes to multiple-limb studies recently introduced in CPT® 2012.
- SEP and MEP may be IONM and may be time based.

inpatient or outpatient labs when testing four limbs, as shown in the following example.

Case 1: A 17-year-old female has a history of tingling in the left leg and blurred vision over the past six months, on and off. She is otherwise healthy and on no current medications. A diagnosis of multiple sclerosis is considered and further workup is scheduled to include a lower extremity SEP and visual evoked response (VER).

Coding for VER is 95930 *Visual evoked potential (VEP) testing central nervous system, checkerboard or flash*; the four-limb SEP is reported with 95938.

SEP and MEP May Be IONM Base Procedures

Codes 95938 and 95939 also may serve as “base procedures” when reporting IONM, as described by +95920 *Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure)*.

Prior to performing IONM, the monitoring physician may first conduct one or more studies to establish a patient’s “baseline” responses. You may report these studies in addition to IONM. CPT® provides a list of approved baseline studies for use with IONM, which includes four-limb SEP or MEP, as well as electromyography (EMG), nerve conduction studies, and others.

Code 95920 is time based: For each hour of monitoring, you may report one unit. You cannot count “standby time” or time spent conducting baseline studies as IONM time, and you must report a minimum of 31 minutes of monitoring to bill for the next hour

of service, as demonstrated:

Monitoring time

30 minutes or less: Not reported separately

31-90 minutes: 95920 x 1

91-150 minutes: 95920 x 2

151-210 minutes: 95920 x 3

Only a dedicated physician with the sole task of monitoring the patient during the surgery should separately claim IONM services.

Recent guidelines in intraoperative spinal monitoring have been published in *Neurology*®, helping to clarify the role of transcranial electric motor and SEP in spinal surgeries presenting an injury risk to spinal motor and sensory tracts. These guidelines indicate IONM can prevent the risk of paralysis or paraparesis by alerting the surgical team to the presence of changes in time for intervention. This intervention may include removal of hardware, loosening of hardware, raising blood pressure parameters, adjustments to anesthesia, or a variety of other possible interventions during the surgical procedure.

Coding Examples Show You the Way

Appropriate use of the new four-limb SEP and MEP codes within 95920 can be shown using more example cases:

Case 2: A 15-year-old female with a history of scoliosis is to undergo anterior and posterior spinal fusion with instrumentation. Due to the risk of motor and sensory track injury during surgery, IONM is performed. Transcranial motor evoked poten-

Only a dedicated physician with the sole task of monitoring the patient during the surgery should separately claim IONM services.

tials (TcEP) and SEP are monitored during this case, and monitoring continues for six hours. Some changes in SEP occur as a result of blood pressure (BP) changes, and medication changes were made to raise the mean arterial blood pressure (MAP) with improvement of the BP.

Proper CPT® coding is 95939 (1 unit includes all four limbs) and 95938 (1 unit includes all four limbs), plus 95920 x 6 (hourly code times number of hours).

Case 3: A 14-year-old patient is scheduled for repair of tethered cord and spinal fusion. He has a history of refractory seizures, which are poorly controlled, and he is on a

three-drug antiepileptic regimen. Because of this patient's epilepsy history, the monitoring and surgical teams decide that TcEP will not be obtained during the surgical procedure; although EMG monitoring, as well as SEP testing, will be obtained.

Proper coding for the EMG is 95870 *Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters* because fewer than four muscles were tested in each extremity, and nerve conduction studies were not done. SEP is reported using 95938 for all four limbs. Hourly IONM is reported using 95920, multi-

plied by the number of hours monitoring occurs.

In all cases, the diagnosis(es) linked to the IONM and baseline study codes should match the diagnosis(es) that the surgeon uses to justify the primary surgical procedure.

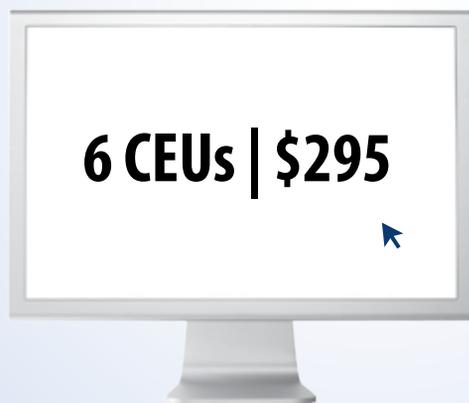
Be sure to append modifier 26 *Professional component* to 95920, as well as any baseline study code(s) billed. The facility will bill separately for the technical portion (equipment and supplies) of the services. ■



Gloria Galloway, MD, FAAN, is a professor of neurology at Ohio State University Medical Center, in Columbus, Ohio.

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A&P Quiz Answer

The correct answer to the A&P question on page 37 is **A**: Acral lentiginous melanoma (ALM) is a form of lentiginous melanoma that typically originates on the feet, hands, toenails, fingernails, and inside mucous membranes. ALM accounts for only about 5 percent of melanoma cases in the United States, but is the leading cause of skin cancer deaths.

A Busy Chapter Is a Successful Chapter

Kansas City found the secret to local chapter success.

For one AAPC local chapter, being successful means staying busy. Kansas City, Mo.'s KC Chapter takes pride in doing more than just educating its members; it also inspires community and membership involvement.

Education

KC Chapter offers a study hall for those who are preparing for or re-taking the certification exam. Anyone can participate in the teaching aspect, since everyone has something to offer. There is no set format for the class and it is geared toward making students more comfortable while they take the test. The study hall meets on a monthly basis and is open to all AAPC members and students free of charge.

Community Charity

KC Chapter also stays busy with community projects. Our first annual charity event in 2010 was a drive for bone marrow donors. Members were encouraged to include employers and friends in the project. This pilot project brought out the best in the chapter and the response was overwhelming. Inspired by success, KC Chapter chooses a different charity each year to present to its membership for personal participation.

In 2011 the emphasis was on Camp Hope, a place where a child with cancer can go for a week and enjoy camp life and still receive treatment for their condition. This year the local chapter is raising

money for Ronald McDonald House. Special door prizes, as well as "points," are awarded to members for donations and participation.

Member Involvement = Points

Points are given to members for volunteering at meetings and events, helping in the study hall, mentoring, working on committees, and participating in other chapter-run services. Each activity is assigned a specific number of points. At the end of the year, prizes are awarded to those who have excelled and worked hard to earn points. This has proven to be a successful means of getting those who would normally feel more comfortable remaining in the background to share their talents and expertise with others.

Staying Busy = Success

KC Chapter offers its members numerous other opportunities each month to encourage growth in membership, both in number and involvement. Although education is the No. 1 priority for KC Chapter, member involvement is the key to this chapter's success. Striving for excellence on a daily basis and staying busy in the industry, as well as the community, offers its own rewards. [C](#)



Rena Hall, CPC, began her career in the medical field as a medical assistant in 1982. She became a certified coder in January 2001 and has been an active member of the AAPC Kansas City, Mo. Local Chapter since her certification. Rena has worked for the same neurosurgery group for almost 26 years.



At the end of the year, prizes are awarded to those who have excelled and worked hard to earn points.



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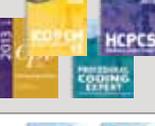
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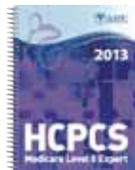
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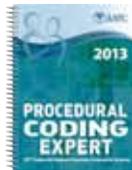
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