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**On the Cover:** As the future of health care unfolds, there are so many coding career options to choose from. New AAPC NAB President Cynthia L. Stewart, CPC, CPC-H, CMPA, CPC-I, CCS-P, is here to help coders find their path. Cover photo taken at St. Vincent Health, Indianapolis, by Jennifer Driscoll Photography (www.photosbyjennifer.com).
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Serving AAPC Members
The membership of AAPC, and subsequently the readership of Coding Edge, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

- **APPRENTICE**
  - Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.

- **PROFESSIONAL**
  - More sophisticated issues including code sequencing, modifier use, and new technologies.

- **EXPERT**
  - Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

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Our National Advisory Board (NAB) includes 16 members appointed by AAPC, representing eight geographical regions of the United States and four officers elected by the NAB including president, president-elect, member relations, and secretary. The role of the NAB is to advise AAPC leadership on coding issues, trends, and member needs, and enthusiastically promote and to support AAPC’s mission and the coding profession. Each NAB representative becomes an ambassador for AAPC and its membership. Every two years a new NAB is elected to represent us. Our new board has been appointed for the next two years.

Another NAB Chapter Is Written
It is amazing how fast the years fly by. I remember handing over the gavel to NAB President Terrance C. Leone, CPC, CPC-P, CPC-I, CIRCC, just two short years ago. It was a very surreal time for me because I really loved serving the membership of AAPC and I enjoyed all the wonderful people and good works our NAB accomplished. Terry must be feeling much of the same emotion I did when my term ended. He has been a very good colleague and friend of mine for several years. We met serving together as board members and during my term as president. Now it is time to say “goodbye,” but I am certain he will remain just as involved and supportive of AAPC when the new NAB steps into office.

Thanks for a Job Well Done
Thanks to the NAB officers who served with Terry, which include, Cynthia L. Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P, president-elect; Linda Farrington CPC, CPC-I, secretary and Julia Croly, CPC, CPC-P, CPC-I, member relations; and the entire NAB of which there are too many to mention. These wonderful people have been selfless of their time serving the NAB and are commended for their service. Thank you everyone for a job well done.

Welcome Our New Leaders
The entire AAPC welcomes NAB President Stewart and her officers, who include: David B. Dunn, MD, FACS, CPC-H, CIRCC, CCC, CCS, RCC, president-elect; Kerin Draak, MS, RN, WHNP-BC, CPC, CPC-I, CEMC, COBGC, secretary; and Melody S. Irvine, CPC, CPMA, CPC-I, CEMC, CCS-P, CMRS, member relations. The entire NAB has a tough act to follow, and I know Cyndi and her team are up to the challenge. Because of Cyndi’s extensive experience working in the health care industry and as an in-the-trenches coder, she understands our membership, our challenges, and strengths. She will lead our next NAB into a future filled with challenges, such as the electronic health record (EHR) adoption, the 5010 conversion, ICD-10, mandated compliance, and whatever else is next to come. AAPC looks forward to working with Cyndi’s NAB in the next two years and will rely on the NAB’s voice and guidance as health care brings change. Welcome Cyndi and the entire NAB.

Next month, Coding Edge will introduce and feature our 16 new board members.

Until next month, my friends,

Deborah Grider, 
CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P
AAPC President and CEO
New Implementation Dates for Telehealth Services

The implementation dates for expanded Medicare telehealth services codes were changed to Jan. 3, 2011 for providers who bill carriers or Parts A and B Medicare administrative contractors (A/B MACs) and April 4, 2011 for providers who bill fiscal intermediaries (FIs) or A/B MACs. Medicare contractors will not reprocess claims submitted prior to these implementation dates. Such claims brought to their attention will be adjusted. The CR release date, transmittal numbers, and the Internet address for accessing the CR have been revised. All other information remains the same.

In case you missed the first release, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7049 to add 14 HCPCS codes to the list of Medicare telehealth services for:

- “Individual and group Kidney Disease Education (KDE) services;
- Individual and group Diabetes Self-Management Training (DSMT) services;
- Group Medical Nutrition Therapy (MNT) services;
- Group Health and Behavior Assessment and Intervention (HBAI) services; and
- Subsequent hospital care and nursing facility care services.”

CMS has added the following request-ed services to the list of Medicare tele-health services for 2011:

- Individual and group KDE services:
  - HCPCS Level II code G0420 Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour; and
  - HCPCS Level II code G0421 Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour.

- Individual and group DSMT services (with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training):
  - HCPCS Level II code G0108 Diabetes outpatient self-management training services, individual, per 30 minutes; and
  - HCPCS Level II code G0109 Diabetes outpatient self-management training services, group session (2 or more) per 30 minutes.

- Group MNT and HBAI services, CPT® codes: 97804 Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes, 96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients), and 96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present);

- Subsequent hospital care services, with the limitation of one telehealth visit every three days; CPT® codes 99231-99233.

- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days, CPT® codes 99307-99310.

Make billing staff aware of these changes.

“Frequency limitations on subsequent hospital care and subsequent nursing facility care delivered through telehealth do not apply to inpatient telehealth consultations,” CMS says in the revised CR. “Consulting practitioners should continue to use the inpatient telehealth consultation HCPCS codes (G0406, G0407, G0408, G0425, G0426, or G0427) when reporting consultations furnished via telehealth.”


CMS Changes MRI Coverage

The Centers for Medicare & Medicaid Services (CMS) released new coverage guidance for magnetic resonance imaging (MRI) in Medicare beneficiaries with implanted permanent pacemakers (PMs) or implantable cardioverter defibrillators (ICDs), effective Feb. 24, 2011. The implementation date is April 4, 2011.

For MRI services, CR 7296 says Medicare will continue to retain current section 220.2.C.1 contraindications of the NCD Manual. “However, CMS believes the evidence is promising, although not yet convincing, that MRI will improve health outcomes in patients with PMs and ICDs if certain safeguards are in place, and therefore will allow for coverage of MRI for Medicare beneficiaries with implanted PMs or ICDs when those beneficiaries are enrolled in a clinical studies that are approved by CMS for the purpose of gaining further evidence about the utility and safety of MRI exposure.”

See CR 7296 (www.cms.gov/transmit-tals/downloads/R132NCD.pdf) for details, including the list of safety criteria and scientific integrity standards that providers must meet.

CAHs Have New Incentives for Primary Care Services

Payment to critical access hospital (CAHs) paid under the optional method has changed.

According to MLN Matters 7115, section 5501(a) of the Affordable Care Act revises section 1833 of the Social Security Act by adding a new paragraph, Incentive Payments for Primary Care Services (PCIP). The new paragraph states that when primary care services are furnished on or after Jan. 1, 2011 and before Jan. 1, 2016 by a primary care practitioner, 10 percent of the payment amount for such services under the Medicare Physician Fee Schedule (MPFS) (on a monthly or quarterly basis) will be paid.

Eligible primary care physicians and non-physician practitioners furnishing a primary care service in a health professional shortage area (HPSA) may receive both a HPSA physician bonus payment under the established program and a PCIP payment under the new program, beginning in 2011.

PCIP Payments to Critical Access Hospitals

“Physicians and non-physician practitioners billing on Type of Bill (TOB) 85X for professional services rendered in a CAH paid under the optional method have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the CAH, payment is made to the CAH for professional services (Revenue Codes (RC) 96X, 97X or 98X).”

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As I write my first message, spring is in the air bringing a welcome change from the long, cold winter. Like the transition that arrives with spring, I find myself again at the crossroads of change during the end of a National Advisory Board (NAB) term and the transition into the new board’s term. I’m excited and a bit nervous to begin my role as NAB president, and I’m also melancholy as I recall the past four years and my time with two exceptional NABs and the outstanding individual members of each.

2007-2009
From the moment the 2007-2009 NAB was introduced to AAPC membership, it bonded under the challenge of advising and assisting the national office during its recreation of AAPC for its members. Many positive changes came about through the hard work and dedication of this board and its leaders. From the fun and amusingly embarrassing moments of AAPC National Conference skits, to the detailed labors required to advance AAPC to its current level of professionalism, board members dedicated themselves to moving AAPC towards its future. This bond, which remains with many of us today, has provided irreplaceable support to AAPC and myself. I hope it will continue to do so in the future.

2009-2011
The 2009-2011 NAB has been no less exceptional in its dedication and contributions to our membership. During the past two years, the board has worked, both seen and unseen, to continue:

- keeping the momentum going to grow AAPC membership;
- broadening the scope and depth of our profession; and
- keeping pace with advancements in the business side of medicine.

A complete list of the tasks assigned to the 2009-2011 NAB would exhaust the limits of this letter; however, several major board assignments come to mind. The first was the creation of the 100K task force. It was the responsibility of this committee to amplify membership’s national voice by adding volume to our organization. The next task involved forming committees to identify additional credentials needed to enlarge and encompass the scope of an AAPC coder’s work. And most recently, the NAB’s ethics committee was asked to clarify the ethics violation process and revise the AAPC Code of Ethics to reflect more closely the mission and ethics of the current AAPC and its membership.

Our achievements brought positive benefits to our members:

- Membership reached well over 100,000 members, making us the largest medical coding organization and ensuring our voice in the profession.
- Two new credentials were added: the Certified Professional Medical Auditor (CPMA®) and the Certified Professional Compliance Officer (CPCO™).
- The first AAPC Mission Statement was created.

It has been a great honor and privilege to serve with both NAB presidents, Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CEMC, CPMA, COBGC, CPCD, CCS-P, and Terrance C. Leone, CPC, CPC-P, CPC-I, CIRCC. I have learned a great deal from both as mentors and hope to lead the next NAB in a manner which continues to elevate our profession and bring pride to members of AAPC.

2011-2013
So what’s in store for the 2011-2013 NAB? With the pace at which our health care industry is evolving, it’s a tough prediction to make. One thing is certain, though: We will stay our current course of helping members grow within their careers by encompassing their educational needs, providing an environment for a positive exchange of ideas and information, and elevating AAPC as a leader in the health care industry.

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

Letter From Member Leadership

NAB Helps Elevate AAPC in the Health Care Industry
Letters to the Editor

Vascular Coding Orders Need Clarification
I was just reading the article, “Keep Vascular Coding in the Family,” by Kimberly Engel, CPC, in the February 2011 Coding Edge and I believe there is an error on page 20.
In the first column, almost two-thirds of the way down, she states, “The brachiocephalic has two children, the right axillary and right common carotid.” According to my illustrations, the right axillary is a third order following the right subclavian, which would be the correct “first child” from the brachiocephalic.
Diane Cooper, CPC

Technically we are both correct. It is the same vessel and the same order, both second off the brachiocephalic. However, the axillary is also a second order of the subclavian, not a third order.
Kimberly Engel, CPC

Get Chapter Sequencing Priorities Straight
In the March 2011 issue, I noticed a slight error (perhaps a typo) in “Simplify HIV and AIDS Coding” [page 23]. In point 6, “Pregnancy Takes Sequencing Priority,” the article states, “Codes from chapter 15 always take sequencing priority.” This should say that codes from chapter 11 take sequencing priority. Chapter 15 codes deal with conditions originating in the perinatal period and don’t appear on the mother’s record.
Ken Camilleis, CPC, CPC-I, CMRS

As you note, the article should have advised that codes from ICD-9-CM chapter 11—not chapter 15—take sequencing priority. To quote the ICD-9-CM Official Guidelines for Coding and Reporting, “Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions.”
The Official Guidelines further specify that chapter 15 codes “are never for use on the maternal record.”

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Understand How ICD-10 Expands Sepsis Coding

Accurately capture the increased complexity of treating severe sepsis.

Beginning Oct. 1, 2013, diagnosis coding of sepsis, severe sepsis, and septic shock will involve a few changes. For one, you will have many more ICD-10-CM codes from which to choose to fully describe sepsis versus severe sepsis, compared to what ICD-9-CM offers. But not everything will change. The code sequencing rules for fully describing the condition of severe sepsis, for example, will remain unchanged with ICD-10-CM. Understanding what will change and what will remain the same will ease the impending transition between code sets.

Get Familiar with Combination Code Usage

Because ICD-10-CM uses combination coding, sepsis without acute organ failure will require only one code: the code for the underlying systemic infection (A40.0-A41.9). Complete and accurate severe sepsis coding will continue to require a minimum of two codes. The first code sequenced in this combination identifies the underlying organism (Sepsis, A40.0-A41.9) or cause of the sepsis (postprocedural infection, trauma, or burn), followed by a code indicating the extent to which the septic condition has progressed: severe sepsis with or without septic shock.

ICD-10-CM splits the condition of severe sepsis with combination codes R65.21 Severe sepsis with septic shock and R65.20 Severe sepsis without septic shock. As with other combination codes, assigning a separate code for septic shock in addition to the combination code is unnecessary. When documented, any associated organ dysfunction should be assigned following the code for severe sepsis. Although the condition of sepsis and its associated code may not be the first listed for the principle diagnosis, the sequencing of these codes remains the same.

Urosepsis Is No Longer Coded

Another change is the deletion of the urosepsis condition and code. Considered in ICD-10-CM as a nonspecific term and not associated with sepsis, the default code for this condition in ICD-9-CM (S99.0 Urinary tract infection, site not specified) is not carried forward in ICD-10-CM. If the provider documents this condition, further clarification should be sought prior to coding.

See How Sepsis Translates

To see how sepsis translates, compare the associated ICD-9-CM and ICD-10-CM codes in Table A.

Newborn Sepsis Codes Get Specific

ICD-10-CM also will bring changes to newborn sepsis coding, as shown in Table B. ICD-9-CM requires a secondary code in addition to the newborn sepsis code (771.81 Septicemia [sepsis] of newborn) to identify the bacterial infection as the underlying organism. As with non-newborn sepsis codes, ICD-10-CM provides combination codes to identify both the condition of sepsis and the underlying organism (P36 Sepsis of newborn due to streptococcus, group B). If a combination code is not available, assign an additional code to identify the underlying organism (B96). When documented, also assign a code for severe sepsis followed by any associated acute organ dysfunction.

Here’s How Puerperal Sepsis Translates

As shown in Table C, the coding of puerperal sepsis will involve only a change in codes because combination codes for puerperal sepsis and the underlying bacterial cause were not created for ICD-10-CM. Coding for this condition using ICD-10-CM codes will continue to require both the code for puerperal sepsis (O85 Puerperal sepsis) and the code for the underlying infection (B95-B96 Bacterial infections in conditions classified elsewhere). As with ICD-9-CM, do not assign a code for sepsis (A40-A41) because the code for puerperal sepsis (O85) identifies this condition. If documented, an additional code for severe sepsis (R65.2x) should be assigned, followed by documented associated organ dysfunction.

Let’s put it all together and compare use of the two code sets by coding these diagnostic statements:

Sepsis due to methicillin susceptible Staphylococcus aureus (MSSA)

ICD-9-CM: 038.11, 995.91
ICD-10-CM: A41.0

Septic shock and respiratory failure due to methicillin resistant Staphylococcus aureus

ICD-9-CM: 038.12, 995.92, 785.52 Septic shock, 518.81 Acute respiratory failure
ICD-10-CM: A41.0, Z16, R65.21, J96.0 Acute respiratory failure

As you can see, the changes in ICD-10-CM coding eliminate ICD-9-CM’s current code redundancy of coding sepsis due to infectious conditions.

The ICD-10-CM coding system more accurately reflects the clinical significance and increased complexity of treating severe sepsis when presenting with septic shock by identifying the presence of this condition. As before, however, the sepsis rules are lengthy and documentation will continue to play a key role in the proper assignment of the new code set. For a successful ICD-10-CM transition, educate your providers early on about these and other documentation and coding changes.
### Table A: Sepsis, Severe Sepsis, and Septic Shock Due to Infectious or Non-infectious Process

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Nomenclature</th>
<th>ICD-10 Code</th>
<th>Nomenclature</th>
</tr>
</thead>
<tbody>
<tr>
<td>038.0</td>
<td>Streptococcal septicemia</td>
<td>A40.0</td>
<td>Sepsis due to streptococcus, group A</td>
</tr>
<tr>
<td></td>
<td>No code</td>
<td>A40.1</td>
<td>Sepsis due to streptococcus, group B</td>
</tr>
<tr>
<td></td>
<td>No code</td>
<td>A40.8</td>
<td>Other streptococcal sepsis</td>
</tr>
<tr>
<td>038.10</td>
<td>Staphylococcal septicemia, unspecified</td>
<td>A41.2</td>
<td>Sepsis due to unspecified staphylococcus</td>
</tr>
<tr>
<td>038.11</td>
<td>Methicillin susceptible Staphylococcus aureus septicemia (includes staphylococcus aureus septicemia NOS)</td>
<td>A41.0</td>
<td>Sepsis due to Staphylococcus aureus</td>
</tr>
<tr>
<td>038.12</td>
<td>Methicillin resistant Staphylococcus aureus septicemia</td>
<td>A41.0 Z16</td>
<td>Sepsis due to Staphylococcus aureus infection with drug resistant microorganisms</td>
</tr>
<tr>
<td>038.19</td>
<td>Other staphylococcal septicemia</td>
<td>A41.1</td>
<td>Sepsis due to other specified staphylococcus</td>
</tr>
<tr>
<td>038.2</td>
<td>Pneumococcal septicemia [Streptococcus pneumoniae septicemia]</td>
<td>A40.3</td>
<td>Sepsis due to Streptococcus pneumoniae</td>
</tr>
<tr>
<td>038.3</td>
<td>Septicemia due to anaerobes</td>
<td>A41.4</td>
<td>Sepsis due to anaerobes</td>
</tr>
<tr>
<td>038.40</td>
<td>Septicemia due to gram-negative organism, unspecified (includes gram-negative septicemia NOS)</td>
<td>A41.50</td>
<td>Gram-negative sepsis, unspecified</td>
</tr>
<tr>
<td>038.41</td>
<td>Septicemia due to Hemophilus influenza [H. influenza]</td>
<td>A41.3</td>
<td>Sepsis due to Hemophilus influenza</td>
</tr>
<tr>
<td>038.42</td>
<td>Septicemia due to Escherichia coli [E. coli]</td>
<td>A41.51</td>
<td>Sepsis due to Escherichia coli</td>
</tr>
<tr>
<td>038.43</td>
<td>Septicemia due to pseudomonas</td>
<td>A41.52</td>
<td>Sepsis due to pseudomonas</td>
</tr>
<tr>
<td>038.44</td>
<td>Septicemia due to serratia</td>
<td>A41.53</td>
<td>Sepsis due to serratia</td>
</tr>
<tr>
<td>038.49</td>
<td>Septicemia due to other gram-negative organisms</td>
<td>A41.59</td>
<td>Other gram-negative sepsis</td>
</tr>
<tr>
<td></td>
<td>No code</td>
<td>A41.81</td>
<td>Sepsis due to Enterococcus</td>
</tr>
<tr>
<td>038.8</td>
<td>Other specified septicemias</td>
<td>A41.89</td>
<td>Other specified sepsis</td>
</tr>
<tr>
<td>038.9</td>
<td>Unspecified septicemia</td>
<td>A41.9</td>
<td>Sepsis, unspecified</td>
</tr>
<tr>
<td>995.90</td>
<td>Systemic inflammatory response syndrome, unspecified</td>
<td>No code</td>
<td>No code</td>
</tr>
<tr>
<td>995.91</td>
<td>Sepsis (systemic inflammatory response syndrome (SIRS) due to infectious process without acute organ dysfunction)</td>
<td>No code</td>
<td>No code</td>
</tr>
<tr>
<td>995.92</td>
<td>Severe sepsis (SIRS due to infectious process with acute organ dysfunction)</td>
<td>R65.20</td>
<td>Severe sepsis without septic shock</td>
</tr>
<tr>
<td>995.93</td>
<td>Systemic inflammatory response syndrome due to noninfectious process without acute organ dysfunction</td>
<td>R65.10</td>
<td>SIRS of non-infectious origin without acute organ dysfunction</td>
</tr>
<tr>
<td>995.94</td>
<td>Systemic inflammatory response syndrome due to noninfectious process with acute organ dysfunction</td>
<td>R65.11</td>
<td>SIRS of non-infectious origin with acute organ dysfunction</td>
</tr>
</tbody>
</table>

### Table B: Newborn Sepsis Coding Comparison

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Nomenclature</th>
<th>ICD-10 Code</th>
<th>Nomenclature</th>
</tr>
</thead>
<tbody>
<tr>
<td>771.81</td>
<td>Septicemia of newborn</td>
<td>P36.0</td>
<td>Sepsis of newborn due to streptococcus, group A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.10</td>
<td>Sepsis of newborn due to unspecified streptococci</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.19</td>
<td>Sepsis of newborn due to other streptococci</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.2</td>
<td>Sepsis of newborn due to staphylococcus aureus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.30</td>
<td>Sepsis of newborn due to unspecified staphylococci</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.39</td>
<td>Sepsis of newborn due to other staphylococci</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.4</td>
<td>Sepsis of newborn due to Escherichia coli</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.5</td>
<td>Sepsis of newborn due to anaerobes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.8</td>
<td>Other bacterial sepsis of newborn</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P36.9</td>
<td>Bacterial sepsis of newborn, unspecified</td>
</tr>
</tbody>
</table>

### Table C: Puerperal Sepsis Coding Comparison

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Nomenclature</th>
<th>ICD-10 Code</th>
<th>Nomenclature</th>
</tr>
</thead>
<tbody>
<tr>
<td>670.2x</td>
<td>Puerperal sepsis</td>
<td>O85</td>
<td>Puerperal sepsis</td>
</tr>
</tbody>
</table>
Remote Coders: Keep the Lines of Communication Open

Use these tips to prevent distant work interactions from becoming misconstrued.

More than ever, coders work at locations remote from the physician or practice for which they code. Some coders work from home, while others work for a billing service that provides coding services in one location for many physicians. If you are a remote coder, you know there are unique challenges to working for someone you may not have met. The interactions you have with the provider and his or her office staff sets the tone for keeping a beneficial working arrangement. Consider ways to strengthen this relationship. The key is good communication—and when the only correspondence you have with your employer is via e-mail and phone, this is even more important.

Examine E-mail Etiquette

First, consider how you communicate with the physician or his office staff. If you use e-mail, make sure it paints a favorable portrait of your work ethic. There is never a good time to use SMS language (textese) in a business situation. “Wd U like us 2 do this now or L8R? THX!” doesn’t let the recipient know that you are a competent coder. Try to use the best grammar and punctuation you can, and use the spelling and grammar checking features in your e-mail program.

Speak clearly and keep messages short and to the point. A rambling message might cause the recipient to set e-mail aside to deal with later, “when there’s more time.” For a busy office staff or practitioner, that time may never come.

Consider that the person with whom you are corresponding may not have your knowledge of coding or billing. Some physicians keep up to date with the coding world, while others prefer to focus entirely on caring for their patients. Know your clients, so you know how much explanation to provide.

WARNING: Always keep Health Insurance Portability and Accountability Act (HIPAA) regulations in mind, and be careful of how much personal information about a patient you include in e-mail. Ask if the practice has a policy regarding protected health information in e-mails, and consider checking with the “IT guy” to verify the security of the e-mail client you use. A fax or a phone call may be considered more secure. Or, you may choose to use a non-personal identifier, such as medical record number or account number when referring to a specific patient.

Phone Manners Matter

If you make phone calls to the provider, be polite and courteous to the person with whom you are speaking. Remember: You are part of the team. If you leave voicemail, give your name and phone number at the beginning and end of the message so the recipient is able to write down the information without replaying the message multiple times. A busy practice may get a lot of voicemail, and not a lot of time to spend on each one.

Be patient if you don’t receive a call back right away. You never know what emergencies the practice may be attending to, or...
if they are shorthanded. Don’t call repeatedly if you don’t get a response as quickly as you’d like. Be prepared with anything you might need when you call, so you can avoid putting the practice on hold. Attempt to return their calls promptly—never make your employer feel put off.

WARNING: A phone call leaves no record of what is discussed. If you call the office to get a diagnosis or clarify a performed procedure, get this information in writing. It protects the practice in case an external auditor comes knocking, and it protects you when your employer audits your work.

Follow Your Provider’s Lead
Lastly, always respect the provider’s preference. One doctor may not have a computer in his office and prefer you call with questions. Another may hate answering the phone, or just not have time during hospital rounds, and would rather receive e-mail. One practitioner may be irritated by text messages, while another may do everything from his phone except make actual phone calls. Communicating in the manner your physician prefers will help ensure you receive a response.

Sticking to good business practices—as well as using common courtesy—will go a long way towards proving to your employer you’re a professional coder.

Jenifer Cooper, BA, CPC, RCC, is the coding supervisor for Professional Billing, Inc. She has seven years of experience in billing and coding. She most recently earned her Radiology Certified Coder designation and is studying towards the CIRCC certification.

Supercoder.com’s Claim Scrubber is a web based automated tool that helps you decrease denials, optimize reimbursement, and ensure coding compliance before you submit your claims. Your claims are instantly checked against our most comprehensive set of clinical edits. Errors are instantly flagged so you can take the steps you need to take to ethically get your pay and stay off the auditors’ hit lists.

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There are two types of annual wellness visits (AWVs): an initial visit (G0438 Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit) and a subsequent visit (G0439 Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit). These visits do not replace the “welcome to Medicare” visit (initial preventive physical exam (IPPE)) that has been covered since 2005. Rather, they are in addition to the IPPE. The requirements for each of these services are very similar:

IPPE and AWV services require very little physical examination, other than routine measurements. In contrast, if patients and physicians were asked to describe a “physical,” it likely would involve a head-to-toe examination and discussion of age-appropriate risk factors. Routine physicals, as described by CPT® 99381-99397, have never been covered under the Medicare program. Whether commercial payers cover preventive services depends entirely upon the individual patient’s plan coverage.

### Code Medicare’s Preventive Visits from Head to Toe

Know what these services really entail.

<table>
<thead>
<tr>
<th>Service Name</th>
<th>HCPCS</th>
<th>Coverage Limits</th>
<th>Required Elements</th>
</tr>
</thead>
</table>
| Welcome to Medicare Visit, IPPE    | G0402       | Once in a lifetime - within the first 12 months of Medicare eligibility          | 1. Review and documentation of the patient’s medical and social history  
  2. Review and documentation of patient’s potential risk factors for depression and/or other mood disorders  
  3. Review and documentation of patient’s functional ability and level of safety  
  4. Physical examination, including height, weight, BP, visual acuity, and BMI  
  5. End-of-life planning  
  6. Education, counseling, and referral (if necessary) based on the five items above  
  7. Education, counseling, and referral (brief written plan) for other preventive services |
| Screening EKG                        | G0403 (global)  
  G0404 (tracing only)  
  G0405 (interp/report only) | One time only (covered only in conjunction with IPPE) | 1. Establish or update of the patient’s medical and family history  
  2. Review of individual’s potential risk factors for depression and/or other mood disorders based on appropriate screening instrument  
  3. Review and documentation of patient’s functional ability and level of safety based on direct observation or use of appropriate screening questions  
  4. Physical examination, including height, weight, BP, BMI (or waist circumference), and other routine measurements appropriate based on history  
  5. Establishment of a list of current providers and suppliers involved in providing medical care to individual  
  6. Detection of any cognitive impairment  
  7. Establishment of a written screening schedule for the next 5-10 years, as appropriate, based on USPSTF and ACIP recommendations, health status, screening history, and age-appropriate preventive services covered by Medicare  
  8. Establishment of a list of risk factors and conditions of which interventions are recommended or underway for the individual, including those identified through an IPPE and a list of treatment options and associated risks and benefits  
  9. Provision of personalized health advice to the individual and referral, as appropriate, to programs aimed at reducing identified risk factors including weight loss, physical activity, smoking cessation, fall prevention, and nutrition |

**By Joyce Will, CPC**
When the physician provides a problem-oriented service, or sick visit, with an IPPE or AWV, remember these guidelines:

- **New Patients**: Do not bill both services together regardless of the insurance because the history and exam elements overlap and documentation can only be counted once. Both the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services state, “a review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient.” New patients fit in this category. The IPPE and AWV also require patient past medical, family and/or social history. Counting work done once for two billed services is “double dipping.”

- **Established Patients**: Documentation for the sick visit requires a chief complaint and history of present illness, with medically necessary exam and decision making for the problem being treated. Other history components are tied up in the requirements of the IPPE or AWV and would not count towards documentation of the sick visit.

### IPPE and AWV services require very little physical examination, other than routine measurements.

<table>
<thead>
<tr>
<th>Service Name</th>
<th>HCPCS</th>
<th>Coverage Limits</th>
<th>Required Elements</th>
</tr>
</thead>
</table>
| AWV, including PPPS, subsequent| G0439    | Annually, but not within 12 months of initial visit (G0438)                     | 1. Update of the patient’s medical and family history  
2. Update list of current providers and suppliers involved in providing medical care to individual  
3. Physical examination, including weight, BP, and other routine measurements appropriate based on history  
4. Detection of any cognitive impairment  
5. Update written screening schedule for the next 5-10 years, as appropriate, based on USPSTF and ACIP recommendations, health status, screening history, and age-appropriate preventive services covered by Medicare, established at initial visit  
6. Update list of risk factors and conditions of which interventions are recommended or underway for the individual, including those identified through an IPPE and a list of treatment options and associated risks and benefits  
7. Provision of personalized health advice to the individual and referral, as appropriate, to programs aimed at reducing identified risk factors including weight loss, physical activity, smoking cessation, fall prevention, and nutrition |
New Annual Wellness Visit: Boon or Trap?

Understand the requirements for appropriate reimbursement.

As required by the Patient Protection and Affordable Care Act (PPACA), the Centers for Medicare & Medicaid Services (CMS) recently amended the Code of Federal Regulations (CFR) to include an annual wellness visit (AWV) for Medicare beneficiaries. The revenue for this service is significant, and it may be performed in addition to an evaluation and management (E/M) service at the same visit; therefore, it is in a providers’ financial interest to offer this new service. Coders must understand the requirements and nuances of the new benefit, so charges can be submitted properly for appropriate reimbursement.

AWV Isn’t a Typical Annual Physical

This AWV is “free” to Medicare patients, in that no co-pay or deductible will apply. Jurisdiction Medicare administrative contractors (JMACs) are reimbursing the initial AWV at approximately $150, and the subsequent AWV at roughly $100. This reimbursement should ensure that patients are offered the benefit.

The AWV is not the annual physical examination that most physicians were trained to perform, however. Physicians who complete a routine annual checkup and expect to submit this service for payment under the new benefit rules will fall far short of meeting the AWV requirements. The AWV contains little “hands on” examination, but when properly performed will help to identify important health risks and ensure Medicare patients receive the screening services they are due.

The intent of the initial AWV is to assess nine areas:

1. Establish the patient’s past family, medical, and surgical history
2. Document the patient’s current medications and supplements, to include specifically calcium use and multi-vitamin use
3. Generate a list of the patient’s current health care providers, including home health agencies and durable medical equipment (DME) providers
4. Measure the patient’s vital signs and body mass index (BMI)
5. Assess the patient’s risk for depression
6. Assess the patient’s cognitive ability
7. Assess the patient’s risks for falls or injury
8. Determine and recommend the preventive health services that are due
9. Document the identified health risks and provide advice and referral, as appropriate and indicated, for these risks

As originally proposed, the AWV also included counseling for end-of-life planning. This “voluntary advance care planning” provision formed the foundation of the ballyhooed “Death Panel” criticisms directed against the PPACA. Under pressure from congress and the public, CMS notified providers on Jan. 10, 2011 that it had rescinded this requirement.

Tip: The interview format of the AWV involves asking a lot of direct, personal questions that may make some patients uncomfortable. You may wish to notify patients beforehand that their visit will be different, and explain the reason behind the changes in the usual encounter format. The sample letter shown in Figure A provides one example of how a practice might accomplish this.

Meet and Document Screening Specifics

The Medicare Benefit Policy Manual, chapter 15, section 280.5, requires that depression screening be “based upon the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations” (www.cms.gov/transmittals/downloads/R134BP.pdf).

This can be interpreted that a standardized screening instrument must be administered and scored, fully and properly. Providers should look at several of these, such as the MacArthur Initiative on Depression’s PHQ-9, or the Beck’s Depression Inventory. Sample PHQ-9 forms are widely available on the Internet (e.g., www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire_sample/). There are other instruments available; whichever is selected, however, must be administered in its entirety and meet the standard of being “recognized by national professional medical organizations.”

In contrast, the rules state that the evaluation to assess fall risk may be “based on direct observation or the use of appropriate screening questions or a screening questionnaire…” Cognitive evaluation screens similarly may be “based on direct observation with due consideration of information obtained by way of patient reports, concerns raised by family members, friends, caretakers, or others.” It’s a good idea to incorporate a few components each from standardized Fall Risk and Cognitive Assessment tools into the AWV documentation. For example, documentation of a modified “Get Up and Go” test and a few points of the Mini Mental Status exam would meet the requirements.

When the evaluation is completed, there must be documentation that the results and identified risks were presented to the patient. Documentation of risk counseling and assessment of preventive services that are due, as well as a schedule of services due over the next five to 10 years, also is required. The patient must receive a written copy of the findings and recommendations.
Requirements Differ for Subsequent Wellness Visits

The subsequent AWV requires a lesser evaluation than the initial AWV, as follows:

1. Update the patient’s past family, medical, and surgical history.
2. Update the list of the patient’s current health care providers.
3. Measure the patient’s vital signs and BMI.
4. Reassess the patient’s cognitive ability.
5. Update the preventive health services schedule developed at the initial AWV.
6. Update the list of risk factors for which intervention is recommended.
7. Document the identified health risks, and provide advice and referral, as indicated, for the identified risks from both this encounter and the initial AWV.

The most significant difference between the initial and subsequent AWVs is that the latter does not include depression or fall risk screenings. These are relatively easy to complete as part of the evaluation, however, and providers would be well advised to perform and document initial and subsequent AWVs in the same manner.

By requirement, the patient must receive a written summary of the risk assessment and recommendations. This summary must include a preventive care screening schedule for the next five to 10 years, and should document counseling and referrals, as necessary, for all the health risks identified in the AWV. The record should document that the points of the summary were reviewed with the patient, and that the patient received a copy of the summary.

Timing Is Everything

The initial preventive physical examination (IPPE) or “welcome to Medicare exam,” the initial AWV, and all subsequent AWVs must occur at least one year apart. The IPPE also must take place within six months of the patient’s Medicare eligibility. Providers must pay attention to the timing of these evaluations to ensure proper reimbursement. Patients are eligible for only one AWV per year, so it will be important to determine whether the patient might have had an AWV from another provider in the previous 12 months.

A Win-win for Patients and Providers

The AWV will be a significant source of revenue for providers. As aforementioned, CMS also specifically has allowed distinct and separate E/M services to be provided and billed at the same encounter. As providers learn of the significant revenue available from these evaluations, there likely will be a stampede of interest in providing the AWV.

If undertaken without careful forethought and planning, billing for the AWV could be a trap waiting to ensnare your providers. When correctly implemented, however, the AWV will help to improve the health and wellbeing of many elderly patients. As coders, we can help shoulder the responsibility of seeing that the key elements of the AWV are provided before the service is submitted for payment. By understanding and explaining the proper application of CMS rules in the provision of the AWV, coders can help ensure this unique encounter is a win-win for the provider team and the patient.

Dr. Spain has been engaged in the full time practice of family medicine for over 25 years. In 1998, he founded Doc-U-Chart, a practice management consulting firm specializing in medical documentation. Dr. Spain can be reached at sspain@docuchart.com.
Meet Criteria for IP-only Procedures Under the OPPS

Reimbursement depends on whether services are inside or outside the scope of payment.

Since the initiation of the Outpatient Prospective Payment System (OPPS), the Centers for Medicare & Medicaid Services (CMS) has maintained a list of procedures that are covered and reimbursed to facility providers only when provided on an inpatient (IP) basis.

**What Is an “IP-only Procedure?”**

Section 1833(t)(1)(B)(i) of the Social Security Act gives the secretary “broad authority” to decide which services will be covered and reimbursed under the OPPS, and which services fall outside the scope of payment under the OPPS. CMS bases its coverage decision on three established criteria:

1. The invasive nature of the procedure
2. The need for at least 24 hours of postoperative recovery time or monitoring before the patient can be discharged safely
3. The underlying physical condition of the patient undergoing the procedure

Based on a review of all invasive procedures performed for the Medicare population, CMS’ medical advisors and staff determine which procedures always should be performed on an IP basis—either because they are not safe or appropriate to perform on an outpatient (OP) basis, or because acceptable medical practice dictates that IP status is the only acceptable environment.

The IP-only list is reviewed yearly by the CMS medical staff and APC Advisory Panel, is opened to public comment regarding which procedures might be removed, and then is updated each year in the OPPS rulemaking cycle. The procedures are assigned to Status Indicator C in Addendum B, and listed as a group in Addendum E.

The IP procedure list is national coverage policy and binding on all entities providing care (hospitals, ambulatory surgical centers (ASCs)) or adjudicating payment (fiscal intermediaries (FIs)/Medicare administrative contractors (MACs), Peer Review Organizations) under the OPPS. If a procedure on the IP-only list is performed on an OP basis and reported on an OP claim, no payment is made to the facility for the IP procedure or for any other services provided on the same date of service. All services that would have been paid as an OP are not reimbursed because they were performed with an IP-only procedure.

There are two exceptions to the non-payment rule:

1. An IP-only procedure is provided to a patient who expires before being admitted as an IP, or is transferred before being admitted as an IP. The IP-only procedure is reported with modifier CA Procedure payable only in the IP setting when performed emergently on an OP who dies prior to admission and a flat rate payment is made to the facility.
2. The IP-only procedure is defined by CPT® as a “separate procedure,” and there is another procedure on the claim that is payable under OPPS and assigned status indicator T Significantly procedure subject to multiple procedure discounting that is paid by APC. The line item for the IP-only procedure is denied but the other services are reimbursed.

**Why It Matters**

CMS believes that physicians consider what is in the best interest of the individual patient, and take into account both the risk of providing the service in an OP scenario and the individual clinical situation. Hospitals and ASCs provide services based on physician order and direction. Yet, although payment is denied on the OPPS side for these procedures, payment is not denied to the physician because professional reimbursement is not provided under OPPS.

For example, a physician can determine that OP status is appropriate for the individual procedure, document this in the patient’s record, perform the invasive procedure and receive reimbursement, while the facility that provided the surgical suite, staff, and equipment is denied payment because the procedure HCPCS code is assigned to the IP-only list, and national coverage policy states this is not a reimbursable service under the OPPS.

To prevent this outcome, the hospital/ASC needs the physician to write an order for IP status to meet the CMS requirements for the service that was rendered.

**Education Is Key**

CMS has tasked hospitals and ASCs with educating physicians on the need to admit the patient as an IP for procedures on the IP-only list so the facility can receive reimbursement for the procedure. This has been difficult because the payment methodologies for the
same service are different, and physicians may not be familiar with the IP-only list.

Hospitals have attempted to educate physicians on the IP-only rule with mixed reviews. There is a lot of pressure on physicians to practice based on insurance rules, and here is yet another “rule” to follow that doesn’t affect them directly.

Over time, the most difficult scenario under which to manage an IP-only procedure has been when the planned procedure is an OP procedure, but based on the clinical scenario present during the performance of the procedure, an IP procedure ultimately is performed. Coding is not done during the procedure, so the actual code assignment is not known until the physician’s dictated report is available. For OP procedures, the patient has been discharged and no IP order was written. And, no order equals no payment.

There usually are a specific number of IP-only procedures that are identified as being most commonly performed on an OP basis for an individual facility. Using this list as a starting point will help focus education efforts. Education is most successful when physicians understand that what affects the hospital in this case, also affects physicians and their patients. A team effort is required to provide appropriate care for the beneficiary while meeting the rules/requirements for Medicare reimbursement.

The mechanism of providing this education depends on the individual hospital environment: Some have found one-on-one education with physician and office staff to be effective; some have found that a group gathering is beneficial; others have disseminated information through the individual discipline divisions with assistance from the MedExec committee or division chiefs.

References
CMS Claims Processing Manual (pub 100-04), chapter 4, section 180.7
CMS-1504-FC (Federal Register/vol. 75, No. 226 / Wed., Nov. 24, 2010)
HCFA-1005-FC (Federal Register/vol. 65, No. 68 / Friday, Apr. 7, 2000)
CMS-1206-FC (Federal Register/vol. 68, No. 216 / Friday, Nov. 7, 2003)

Denise Williams, RN, CPC-H, is the director of revenue integrity services for Health Revenue Assurance Associates, Inc. She has been involved with APCs since their initiation. Denise also has worked as corporate chargemaster manager for two health care systems, and is heavily involved in compliance and coding/billing edits and issues.

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Be Complete, Be Current
The CPT® Professional Edition is published each year by the American Medical Association (AMA), and is available as a print publication, as a CD, or via the Internet (the electronic version may be configured for one or more users). The AMA owns the copyright to the codes, their descriptions, and guidelines for use. You may purchase AMA’s CPT® Professional Edition through AAPC and other vendors. Only the AMA CPT® Professional Edition is permitted for use in AAPC credentialing exams, and it is the only version that includes official guidelines.

Be sure you’re always using the most current version of the CPT® book. Codes and coding guidelines change every year, and if you’re using an outdated edition, your coding accuracy is guaranteed to suffer. Saving a few dollars by using last year’s edition is no bargain when you consider the inevitability of miscoded, delayed, and/or rejected claims. The Health Insurance Portability and Accountability Act (HIPAA) also requires the use of current CPT® codes, so if an auditor finds you using an outdated CPT® book, you will solicit little sympathy.

Take a Tour of CPT®
The typical busy coder references the CPT® index as needed, double-checks the code(s) and parenthetical instruction in the numerical listings, codes that portion of the claim, and quickly moves on. The wise coder knows, however, that it’s worth investing time to study the book a bit more closely. The introductory materials, for instance, aren’t just filler. These often-overlooked portions of the book are invaluable resources.

You’ve probably noticed the list of modifiers and modifier descriptors on the front inside cover, and the Place of Service (POS) code listing on the facing page, but what if you venture a few pages further?

The Introductory (pages x-xiii of the CPT® 2011 Professional Edition) summarizes the layout of the CPT® book, how the codes are listed and defined, and modifier use; and defines terminology and the various symbols used throughout the book. Sure, this is basic information. But, just as you must know how to add and subtract before you can do long division or solve algebraic equations, so too does complex coding rely on a solid understanding of fundamental concepts. You’re never too advanced to review the essentials, and it’s wise to do so with every new release. Several icons and features are new in the last decade.

Which Way Is Up?
Pages xiv-xviii of CPT® 2011 Professional Edition provide a list of medical prefixes, suffixes, and word roots, as well as anatomic illustrations demonstrating body planes and aspects (sagittal plane, anterior aspect, etc.) and a list of illustrations that appear throughout the book. For example:

- Curious about brain anatomy? See Figure 18A.
- Want a pictorial explanation of abdominal aortic aneurysm repair? See the illustration that accompanies code 34802 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using bifurcated prosthesis (1 docking limb).

Often, a visual representation of a concept or procedure allows the coder literally to picture the correct coding, and the CPT® book provides a great variety of resources to facilitate this.

E/M Tables Simplify Code Selection
The CPT® Professional Edition contains tables in the Evaluation and Management (E/M) Services Guidelines section listing the required key components and, when applicable, typical service time for various categories/levels of E/M services (office or other outpatient services, initial hospital care, etc.). These tables provide an at-a-glance reference to help you select an appropriate E/M service level when the key components and/or counseling/coordination of care time have been documented and determined.

Decision Tree Takes a Vacation, but Still Applies
The New vs. Established Patient Decision Tree, which previously was included in the Evaluation and Management
Often, a visual representation of a concept or procedure allows the coder literally to picture the correct coding, and the CPT® book provides a great variety of resources to facilitate this.

(E/M) Services Guidelines section, does not appear in the CPT® 2011 Professional Edition. Peter A. Hollmann, MD, vice chair of the AMA CPT® Editorial Panel, announced on Nov. 10, 2010 at the CPT® and RBRVS 2011 Annual Symposium in Chicago that the omission of the New vs. Established Patient Decision Tree from CPT® 2011 does not represent a change in policy regarding how to determine whether a patient is new or established. The definition of “new” and “established” patients in the Evaluation and Management (E/M) Services Guidelines remains unchanged from 2010. Hollmann predicts the New vs. Established Patient Decision Tree will reappear in the 2012 edition of CPT®.

Be on the Lookout for Coding Tips
Also new for 2011, the AMA has included supplemental coding tips throughout CPT® Professional Edition. These tips, set apart with a green “Coding Tip” indicator, provide valuable information for appropriate code selection, and are separate from the parenthetical and section head instructions most coders already know.

For example, preceding the Other Emergency Services codes, CPT® 2011 Professional Edition includes a Coding Tip advising, “No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.” Be sure to read and observe such Coding Tips to assist you in your code choices.

The Coding Tips are concentrated in the E/M portion of CPT® for 2011, but look for these helpful hints to become more widespread in years to come.

Follow Citations for Supplemental Coding Advice
Throughout CPT® you will find citations to CPT® Assistant (designated by an arrow within a green circle) and Clinical Examples in Radiology (designated by an arrow within a red circle). Although not an official part of the CPT® book, advice from either of these publications provides supplemental information on, and examples of, proper code use. These citations are useful especially when differentiating among several similar codes (or modifiers). The extra legwork to find and follow the citation often pays for itself.

To give just one example: If you must report colpopyexy (57280 Colpopyexy, abdominal approach, 57282 Colpopyexy, vaginal; extra-peritoneal approach (sacrospinosus, iliococcygeus), 27284 Colpopyexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy) the CPT® Assistant reference (January 1997) instructs, “during reconstructive pelvic surgery, when either a vaginal or abdominal paravaginal defect repair is performed for correction of stress urinary incontinence or cystocele formation, and in addition a separate procedure for correction of vaginal vault inversion such a sacrospinous ligament fixation (code 57282) or an abdominal colpopyexy (code 57820) is performed, codes 57282 or 57280 with modifier 51 may be reported in addition to 57284.”

Lacking this information, the coder may fail to report 57282, when appropriate, in addition to 57284. This translates into 7.97 physician work relative value units (RVUs) lost, or approximately $250 at average Medicare rates.

Subscriptions to CPT® Assistant and Clinical Examples in Radiology, as well as archives of past issues, are available through the AMA (https://catalog.ama-assn.org/Catalog/home.jsp).

But Wait! There’s More!
CPT® contains supplemental information in addition to that described above, including appendices with clinical examples, a summary of codes exempt from modifiers 51 Multiple procedures and 63 Procedure performed on infants less than 4 kgs, a list of separate nerves for electrodiagnostic testing (especially helpful for neurology coders), and much more. There’s also a handy list of common abbreviations on the inside back cover. In other words, there’s probably more to your CPT® book than you knew.

Take the time to page through your CPT® book and identify those resources that you find most helpful. Remember, it’s not a sacred text: You’re allowed (and encouraged) to make notes in the margins, underline and highlight pertinent information, add your own tabs for easy reference, or incorporate “cheat sheets” within its pages. If you make the most of the resources at hand, your value as a coder appreciates. ☑

Brad Ericson, MPC, CPC, COSC, is AAPC director of publishing.
Case Study:  
The Fundamentals of Time

If you haven’t reviewed the Introduction recently, you might be surprised to discover a new (added in 2011) explanatory paragraph on Time, as it relates to CPT® coding. Here you’ll find essential time information.

Unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary:

- Time is face-to-face time with the patient.

Note that many inpatient services, as well as subsequent observation care 99224-99226 (technically an outpatient service) define time as bedside or floor/unit time. This is one case where descriptor-specific instructions override general guidelines.

- Phrases such as “interpretation and report” in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time.

- A unit of time is attained when the mid-point is passed.

As an example, critical care services (99291-99292) are time based, with 99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes reporting the first hour of critical care. To report 99291, the length of service must exceed the “half-way” mark, or at least 31 minutes. Critical care lasting fewer than 31 minutes is reported using an appropriate evaluation and management (E/M) code, rather than 99291. Similarly, +99292 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service) reports “each additional 30 minutes” of critical care, in excess of the first hour. This means that to report +99292, at least 75 minutes of critical care must be documented (60 minutes for the first hour, plus at least 15 minutes—the “halfway mark”—to report the additional 30 minutes of critical care as reported by +99292).

- When codes are ranked in sequential typical times and the actual time is between the two typical times, the code with the typical time closest to the actual time is used.

For instance, when reporting a time-based E/M service for an established outpatient, the documented counseling/coordination of care time is 22 minutes. By CPT® standards, this would mean the proper coding is 99214 (Physicians typically spend 25 minutes face-to-face with the patient and/or family), rather than 99213 (Physicians typically spend 15 minutes face-to-face with the patient and/or family), because 22 is closer to 25 than to 15. Note that not all payers agree with this rule. For example, the Centers for Medicare & Medicaid Services (CMS) typically views the E/M reference time as the minimum time needed to report a service.

- When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.

Time spent performing separately-reported services concurrent with critical care services 99291-99292 may not be counted toward critical care time. The Evaluation and Management (E/M) Services Guidelines also have undergone revisions for 2011 to clarify better how time relates to E/M services. A summary of the additions include:

- Verification that non-face-to-face (pre- and post-encounter) time may not be included when calculating total time for an office service

- Notification that the total work of E/M services has been calculated to include non-face-to-face time

- A restatement that time shall be considered the key factor for E/M leveling, when counseling and coordination of care dominate the encounter

- A determination that counseling or coordination of care includes time spent with patients or those individual(s) (including non-family members) who have assumed responsibility for the patient

- A requirement that the extent of counseling and/or coordination of care must be documented in the medical record

- Advice to report add-on codes for prolonged E/M services

The introductory materials ... aren’t just filler. These often-overlooked portions of the book are invaluable resources.
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Meet Stress Testing
Supervision Requirements

Provider rules change depending on whether you’re reporting for inpatient or outpatient services.

When reported to Medicare, cardiac (93015-93024) and pulmonary (94620-94621) stress tests must meet applicable supervision requirements. You also must remember that in the outpatient setting only a physician—never a non-physician practitioner (NPP)—may act as the supervising entity for diagnostic tests.

Know the Supervision Levels Required
Medicare specifies supervision requirements for all diagnostic services, as found in the “Physician Supervision of Diagnostic Procedures” column of the National Physician Fee Schedule Relative Value File. The file lists the following supervision requirement indicators for stress tests:

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
<th>Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>93015</td>
<td>Cardio stress test/w physician supervision/w interp. and report</td>
<td>2</td>
</tr>
<tr>
<td>93016</td>
<td>Cardio stress test/supervision only</td>
<td>2</td>
</tr>
<tr>
<td>93017</td>
<td>Cardio stress test/tracing only</td>
<td>2</td>
</tr>
<tr>
<td>93018</td>
<td>Cardio stress test/interp. and report only</td>
<td>9</td>
</tr>
<tr>
<td>93024</td>
<td>Ergonovine provocation test/global service</td>
<td>9</td>
</tr>
<tr>
<td>93024-TC</td>
<td>Ergonovine provocation test/tech. comp. only</td>
<td>3</td>
</tr>
<tr>
<td>93024-26</td>
<td>Ergonovine provocation test/prof. comp. only</td>
<td>9</td>
</tr>
<tr>
<td>93025</td>
<td>Microvolt assessment of ventricular arrhythmias/global service</td>
<td>2</td>
</tr>
<tr>
<td>93025-TC</td>
<td>Microvolt assessment of ventricular arrhythmias/tech. comp. only</td>
<td>2</td>
</tr>
<tr>
<td>93025-26</td>
<td>Microvolt assessment of ventricular arrhythmias/prof. comp. only</td>
<td>2</td>
</tr>
<tr>
<td>94620</td>
<td>Pulmonary stress test/simple/global service</td>
<td>9</td>
</tr>
<tr>
<td>94620-TC</td>
<td>Pulmonary stress test/simple/tech. comp. only</td>
<td>1</td>
</tr>
<tr>
<td>94620-26</td>
<td>Pulmonary stress test/simple/prof. comp. only</td>
<td>9</td>
</tr>
<tr>
<td>94621</td>
<td>Pulmonary stress test/complex/global service</td>
<td>9</td>
</tr>
<tr>
<td>94621-TC</td>
<td>Pulmonary stress test/complex/tech. comp. only</td>
<td>2</td>
</tr>
<tr>
<td>94621-26</td>
<td>Pulmonary stress test/complex/prof. comp. only</td>
<td>9</td>
</tr>
</tbody>
</table>

The supervision requirement indicators correspond to the following supervision levels:

1—Procedure must be performed under general supervision: The procedure is furnished under the physician’s overall direction and control. The physician must order the diagnostic test and is responsible for training the staff performing the tests, as well as maintaining the testing equipment. He or she does not need to be present in the room during the procedure.

2—Procedure must be performed under direct supervision: The physician needn’t be present in the room, but must not be performing another procedure that cannot be interrupted, and must not be so far away that he or she could not provide timely assistance.

In the physician office, and for hospital outpatient diagnostic services provided under arrangement in nonhospital locations (such as independent diagnostic testing facilities and physicians’ offices), the supervising phy-
Only “a doctor of medicine or osteopathy legally authorized to practice medicine in his or her state of practice,” may act as a supervisory physician for diagnostic services in an outpatient setting (hospital outpatient or physician office).

Use Caution When Involving NPPs

“Physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives who do not meet the definition of ‘physician’ may not function as supervisory physicians for the purposes of diagnostic tests,” according to the 2010 Hospital Outpatient Prospective Payment System (OPPS) Final Rule (Federal Register, Nov. 20, 2009). Many times we see our NPPs and physicians listed together as a provider type, but when it comes to supervision for these tests, this cannot be the case. Only “a doctor of medicine or osteopathy legally authorized to practice medicine in his or her state of practice,” may act as a supervisory physician for diagnostic services in an outpatient setting (hospital outpatient or physician office). And, the supervising physician must have the “knowledge, skills, ability and privileges to perform the service or procedure”—so not just any doctor will do.

Note that Medicare physician supervision requirements do not apply to hospital inpatient services. For inpatient services, CMS defers to hospital policy and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. Medicare specifies that NPPs (such as physician assistants (PAs), nurse practitioners (NPs), certified nurse specialties, certified nurse midwife) may order, perform, and bill for diagnostic tests as specifically granted under their state Scope of License, but Public Health Code and other regulations in place still require overarching physician collaboration, or a level of supervision by physicians, in the performance of these tests. To quote the Medicare Benefits Policy Manual, chapter 6, section 20.4.5:

“exceptions . . . allow some diagnostic tests furnished by certain non-physician practitioners to be furnished without physician supervision. While these nonphysician practitioners including physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives cannot provide the required physician supervision when other hospital staff are performing diagnostic tests, when these nonphysician practitioners personally perform a diagnostic service they must meet only the physician supervision requirements that are prescribed under the Medicare coverage rules at 42 CFR Part 410 for that type of practitioner when they directly provide a service. For example, under 410.75 nurse practitioners must work in collaboration with a physician, and under 410.74 physician assistants must practice under the general supervision of a physician.”

The compliance implications of these requirements need to be considered in your practice, particularly if you are performing stress tests. At a minimum, for diagnostic tests in the outpatient setting:

- Be sure that the physician documents specifically the level of supervision provided. CMS guidelines specify, “Documentation maintained by the billing provider must be able to demonstrate that the required physician supervision is furnished.”
- NPPs never may act as a supervising physician.

An NPP looking to order or perform a specific test first should check at a state level to determine if he or she is qualified to do so. If a mid-level provider administers the test without physician supervision, the medical record should document clearly that the service is within the provider’s scope of practice as allowed by state law, and the procedure billed under the name of the NPP.

Jill M. Young, CPC, CEDC, CIMC, has over 30 years of medical experience working in all areas of medical practice including clinical, billing, and rounding with physicians. This gives her a unique style of teaching using real life examples of coding and billing situations in her lectures. She is the principal of Young Medical Consulting, LLC, and is the current chair of ARPC Chapter Association (AAPCCA).
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Find Your Coding Career Path

By Michelle A. Dick
New NAB president focuses on the future as the health care industry changes and opens career options for coders.

AAPC’s newest National Advisory Board (NAB) President Cynthia L. Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P, shows strength, coding enthusiasm, and commitment, and has a sweet disposition that makes her the perfect leader to represent AAPC members. Stewart has worn many hats during her 25 years in the medical profession and has been an outspoken advocate for AAPC since she joined in 1998. Stewart has been with the NAB for the past four years, since 2007, and will serve as president for the next two.

Experience Paves Career Path
Before Stewart became an NAB member, president-elect, and president, she held office as president for the Central Indiana chapter in Indianapolis in 2006. Here, she gained leadership experience and applied her coding experience to help fellow coders. She is an AAPC workshop presenter and has provided instruction as a reviewer, contributing author, and research assistant for various coding and billing texts.

Over the past 15 years, Stewart has applied her coding knowledge to many positions:

- billing supervisor
- practice manager
- senior coding specialist
- coding and reimbursement
- director of medical billing and coding specialist and health care management programs

Her coding and leadership experience has brought her to the current position of revenue cycle systems manager with St. Vincent Health in Indianapolis.

Stewart’s coding specialties are in neurosurgery, neuro-interventional, anesthesia, and orthopedics.

Achievement Backed by Strong Individuals
Stewart has been blessed with the help of many people in attaining her coding goals. “There have been so many people who have boosted me while I pursued my goals. Two in particular rise to the top of the list: my father and Deb Grider,” Stewart says.

Stewart’s father, Lee Stewart, rank Chief Warrant Officer 4 (CWO 4), had an Army career spanning 1950-1975 and was a Korean and Vietnam War veteran. Because Stewart’s father served in many dif-

About ICD-10, Stewart says, “It is the largest and most complex change in health care history, but with proper training and continuing education, our AAPC coders should thrive in the future of health care.”
different locations, she lived in Germany when she was a child. Like Stewart, her father wore many hats including steel warehouse supervisor and instructor for H&R Block. Stewart said that her father “challenged me to find something I could do well and encouraged me to take it further.”

With his strength and encouragement behind her, she faced each new challenge along her coding career path. Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CEMC, CPMA, COB-GC, CPCD, CCS-P, recalls when she first met Stewart, “I met Cyndi many years ago when she first walked into my PMCC class. We both hail from Indiana and became good friends and colleagues.” Since then, Grider said, “Cyndi has been working in the health care industry for many years, as a down-in-the-trenches coder to now as a consultant for a large hospital system.” Stewart recalled being a student in Grider’s class and how it affected the fate of her career. She said, “Deb Grider really did have something to teach me and has been my mentor ever since that fateful course.”

**Exciting Times Lie Ahead**

It’s an exciting time for Stewart to be president, when there are so many career options for coders and big changes in the health care industry. In fact, during her term as president-elect two new credentials, Certified Professional Medical Auditor (CPMA®) and Certified Professional Compliance Officer (CPCO™), broadened coding career options for coding professionals. These two credentials are fitting additions in the current health care climate, where government regulations and compliant coding is a necessity.

Stewart’s NAB is dedicated to moving AAPC into the future and finding new ways to expand the coder’s role and their career options in the health care industry. This is an exciting time when coders have a wide range of career options, including:

- biller
- consultant
- auditor
- compliance officer
- teacher/Professional Medical Coding Curriculum (PMCC) instructor
- specialty coder

**ICD-10 Will Change Everything**

The transition to ICD-10 is another big milestone that coders are faced with over the next couple of years. The coder plays an important part in helping to make a smoother transition. Education is key and a coder’s knowledge is invaluable and vital to troubleshooting potential coding problems before the Oct. 11, 2013 implementation date arrives.

About ICD-10, Stewart says, “It is the largest and most complex change in health care history, but with proper training and continuing education, our AAPC coders should thrive in the future of health care.”

Stewart is excited to be part of AAPC as it evolves with the health care industry’s needs. What excites her most about AAPC? “The constant change while we work to stay on top of the health care industry and the support we give each other while meeting this challenge,” she says. Stewart says she sees its members as a support system taking the coding profession to higher levels and expanding it in new directions.

**Besides Coding, What Else Is There?**

Stewart is the mother of two children, Callie, 25, and Adam, 17, and Nana to two “precious” grandchildren, Keegan, 6, and Madysen, 3. Her grandchildren keep her laughing and on her toes.

Stewart says, “Employment in the medical field seems to run in the family.” She takes pride in the decision both her children have made to follow her into the medical field, “unfortunately not as coders,” Stewart jokes. Callie is a medical assistant with plans to continue her education to become a nurse practitioner. And as her son prepares to enter his senior year, he is dedicating himself to his studies to prepare for medical school. Stewart’s sister, Peggy Johnson, also works in the field as a licensed practical nurse (LPN) and has been a ready source of clinical information when needed.

When Stewart is not working she enjoys recreational activities and keeping busy. She has a different hobby, or two, for every season:

- Winter: reading and writing
- Spring: gardening and fishing
- Summer: boating and camping
- Fall: cooking

Stewart also likes to travel. “As the child of a Dutch mother and military father I have lived and traveled all over the world.” She has seen a lot of countries, but says if she had to choose one place to go for two weeks that was far away from coding, it would be Tuscany. She’d keep busy while she was there. “I like to stay busy so I would have to say two weeks in Tuscany learning to cook real Italian dishes and taking pictures would be wonderful,” Stewart says.

When she has time for television, she enjoys watching her favorite shows, “House” and “The Big Bang Theory,” which she records to watch later with her son.

Michelle A. Dick is senior editor at AAPC.
Don't Be Confused by the Fee-Setting Process Anymore!

RBRVS CALCULATOR

As we all know, setting fees isn’t an art but a science. With straightforward instructions, real-world examples, and easy-to-understand formulas, the RBRVS Calculator is a well-organized resource that will help clarify the fee-setting process.

A free-standing software program, the RBRVS Calculator:

- Reports individual RVUs and calculates adjusted and unadjusted totals as well as calculating the Medicare allowable
- Performs both a complete RBRVS analysis for the 2011 database as well as a practice- or physician-specific Medicare financial impact analysis by comparing RVU, conversion factor and Medicare frequencies for 2010 data to 2011 data

To learn more about RBRVS Calculator, please call us at 1-800-334-5724 or order online at www.codingbooks.com
CPT® 2011 features significant changes to both Category I and Category III codes that eye doctors and their billers ought to know.

**Changes in Cornea**

Amniotic membrane may be used for ocular surface reconstruction by several methods, at varying levels of physician effort. CPT® represents this hierarchy of services with two new codes and one revised code:

- **65778** Placement of amniotic membrane on the ocular surface for wound healing; self-retaining
- **65779** Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured

**65780** Ocular surface reconstruction; amniotic membrane transplantation, multiple layers

These changes have prompted a slew of questions:

**Q.** What are the global periods and typical allowables for 65778 and 65779?
**A.** Per the Medicare Physician Fee Schedule (MPFS), 65778 and 65779 carry a 10-day global period (65780 remains at 90 days).

The typical allowable depends on whether you perform the procedure in the office (65778 - $947/65779 - $857) or in a facility (65778 - $57/65779 - $219). The cost of the tissue is built into the practice expense when performed in the office (thus, the higher allowable for office procedures). When the surgery is performed in a facility, the facility must pay for the tissue (a “pass through” for amniotic membrane was revoked).

**Q.** Can 65778 and 65779 be billed with 65430, 65435, and/or 65780?
**A.** No. CPT® instructs that neither 65778 nor 65779 should be billed with 65430 Scraping of cornea, diagnostic, for smear and/or culture, 65435 Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage), or 65780.

**Q.** Which code should we use for tissue glue?
**A.** CPT® specifies that you should use 66999 Unlisted procedure, anterior segment of eye for placement of amniotic membrane using tissue glue.

**Q.** A pterygium is removed and, rather than placing an autograft, the physician applies a single sutured layer of amniotic membrane. How should this be coded?
**A.** In the office, 65779 with the appropriate eye modifier appended should be listed first because it has the highest allowable, followed by 65420 Excision or transposition of pterygium; without graft with modifier 51 Multiple procedure and an appropriate eye modifier appended.

Note: Many payers no longer require modifier 51—check with your payer for specifics.

In an ambulatory surgical center (ASC), submit 65420 first, followed by 65779 with the appropriate eye modifier.

Note: In the office setting, the physician bears the expense of the amniotic tissue and the reimbursement is higher for 65779. When performed in the ASC, the tissue is bundled into the facility payment for the procedure, and 65420 pays higher.

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**Keep Your Practice Up-to-date on 2011 Ophthalmology**

Find out what’s been revised, added, and deleted within CPT®’s extensive changes.

By Kim M. Ross, OCS, CPC

“CPT® 2011 eliminates two Category III codes for canaloplasty ... and adds two new Category I codes.”
Q. If a pterygium is removed and both an autograft and a single sutured layer of amniotic membrane are used (e.g., for a very large defect), how would this be coded?

A. In the office, use 65779 with an eye modifier and 65426 Excision or transposition of pterygium; with graft with an eye modifier. Payment will be 100 percent of the allowable for the first procedure, and 50 percent of the allowable for the second procedure. If performed in the ASC, 65426 with an appropriate eye modifier should be submitted first because in this setting 65426 has the higher allowable.

Q. How do we code for the ProKera ring?

A. Report 65778.

Q. If a ProKera® ring is inserted post-operatively within the global period of another cornea procedure, how should the doctor bill?

A. If planned prospectively, use 65778 with modifier 58 Staged or related procedure or service by the same physician during the post-operative period. Payment will be 100 percent of the allowable. You’ll need to begin a new 90-day global period.

If the procedure was not preplanned, submit 65778 with modifier 78 Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period. Payment will be 80 percent of the allowable. Continue the global period of the original procedure.

Q. If laser-assisted in situ keratomileusis (LASIK) is performed and the postoperative ProKera® is for a medical reason, can a claim be submitted using 65778?

A. In the case of a medical complication that results from a noncovered procedure, payment is up to the individual payer’s coverage policy.

Q. If multiple layers of amniotic membrane are used with pterygium surgery, without an autograft, is it appropriate to submit both 65420 and 65780?

A. No. The appropriate code is 65426. This code’s descriptor does not specify the material used, or how many layers are used. CPT® 65780 is for ocular surface reconstruction plus multiple-sutured layers of amniotic membrane. The problem with using 65420 plus 65780 is that the physician would be paid twice for removing the pterygium.

There is no code for multiple-layer amniotic membrane transplantation performed as an add-on procedure; in such a scenario, an unlisted procedure code (e.g., 66999) would be used.

Q. How should we code when a single layer amniotic graft is used with sutures and glue?

A. Report 65779.

Q. How should we code for placement of amniotic membrane, without reconstruction, using self-retaining or single-layer suture technique?

A. For the self-retaining technique, use 65778; for the single-layer suture technique, use 65779.

Q. Which is the proper code for multiple layers of amniograft used for ocular surface reconstruction?

A. Code 65780.

**Changes in Glaucoma**

CPT® 2011 eliminates two Category III codes for canaloplasty—0176T and 0177T—and adds two new Category I codes (both of which have a 90-day global period when paid under the MPFS):

- 66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent
- 66175 Transluminal dilation of aqueous outflow canal; with retention of device or stent

Canaloplasty is an advanced treatment for glaucoma that uses microwhether technology to enlarge the eye’s natural drainage system (in a manner similar to angioplasty), thereby helping the aqueous fluid drain properly.

New Category III code 0253T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space (Glaukos shunt) was created specifically to address the route of aqueous egress into the suprachoroidal space. This code is listed out of sequence: The entry for 0253T appears between 0191T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork and 0192T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach.

The MPFS does not include relative value units (RVUs) or values for Category III codes. If Medicare covers the test, payment is at the discretion of the Medicare administrative contractor (MAC), and payments likely will vary. Many MACs have published local coverage determinations (LCDs) for Category III codes. Most non-Medicare carriers consider these emerging technology codes to be “investigational,” and often deny payment.

The descriptor for 66761 Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session) now

“The dramatic increase in the number of SCODI procedures being billed each year put 92135 in the crosshairs of CMS.”
Feature

specifies “per session” rather than “one or more sessions.” In response, the MPFS reduces the global period for this code from 90 days to 10 days.

Codes Eliminated in Retina

Category III codes are reviewed every five years and are eliminated if there is insufficient support for their retention. CPT® 2011 eliminates Category III codes 0016T Destruction of localized lesion of choroid (e.g., choroidal neovascularization), transpupillary thermotherapy and 0017T Destruction of macular drusen, photocoagulation. CPT® now instructs you to use 67299 Unlisted procedure, posterior segment to report these procedures.

Changes in Testing Services

CPT® 2011 eliminates Category III code 0187T and replaces it with 92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral. CPT® also deletes 92135 and replaces it with two new codes:

- **92133** Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
- **92134** Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina

(Per CPT® instructions, do not report 92133 and 92134 at the same patient encounter.)

What prompted these changes in scanning computerized ophthalmic diagnostic imaging (SCODI) coding? The Centers for Medicare & Medicaid Services (CMS) is charged by law to identify codes with the highest rate of growth and to review these codes to determine if they have been valued properly. The dramatic increase in the number of SCODI procedures being billed each year put 92135 in the crosshairs of CMS. The division into an optic nerve code and a retina code was prompted by the distinctly different uses for the service, and will aid clinicians in reporting different services.

Codes 92312-92134 are bilateral for 2011, and will be reimbursed per test, not per eye (the unilateral designation was discontinued because claims data suggested these procedures were performed bilaterally in the majority of cases). Practices should submit these testing services as a single line item, with no modifiers appended to the service.

New Codes in Telemedicine

Finally, CPT® 2011 adds two new codes to meet the needs of diabetic retinopathy screening programs that provide remote imaging and data submission to a centralized reading center:

- **92227** Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral

Per CPT® instructions, these codes should not be submitted with each other, nor should they be submitted with codes 92002-92014, 92133, 92134, 92250, or with evaluation and management (E/M) of a single organ system—i.e., the eye (99201-99350).

Diabetic retinopathy (DR) is a leading cause of blindness. Early detection makes the condition correctable 95 percent of the time. Imaging retina center technicians easily can look at a photo and read it. The ophthalmologist then can determine if the patient has DR—and if so, the stage of DR and the proper course of treatment.

Equate the term “detection” (new diabetic retinopathy imaging code 92227) with “screening” for diabetic retinopathy. In other words, use 92227 when a diagnosis of DR is not certain and the physician is attempting to confirm the diagnosis. When the patient has active DR that is being managed, use 92228 for the imaging.

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**Kim M. Ross, OCS, CPC**, is the American Academy of Ophthalmology’s coding specialist, and the contributing author of the Ophthalmic Coding Coach and the Ophthalmic Coding Module Series. Kim’s 35-year ophthalmic background includes all aspects of clinical and surgical assistance, ophthalmic photography, practice management, coding, reimbursement, and compliance.

Fee Schedule Shake-up Is a Wash for Ophthalmology

For 2011, the Physician Fee Schedule conversion factor is 33.9764. This is lower than the 2010 rate, but ophthalmology was granted an increase in practice expense and malpractice values that offset the reduction. Overall, ophthalmology payments should be stable in 2011. Ophthalmology can expect to gain an additional 4 percent by 2013, when improved practice expense values for ophthalmology are fully implemented in the fee schedule.
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Newly credentialed members

The newly credentialed members listed above have achieved the highest level of professional recognition in their respective specialties. Each individual is recognized for their dedication and expertise in their field, contributing to the advancement of the industry.
Newly Credentialed Members

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Gig Harbor WA

Kimberly Reid, CPC, CPMA, CPC-I, CEMC

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Diane Smith, CPC
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Sheri Upholstery, CPC-A
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Kathy Upholstery, CPC-A
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Lori Upholstery, CPC-A
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Newly Credentialed Members:

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While the job market in many sectors is difficult, the increased focus of the government and commercial carriers on identifying fraud, waste, and abuse—not to mention simple payment error—has opened up much opportunity in the health care compliance arena. For many years, trained compliance professionals had difficulty finding positions in their field. Small to mid-size practices didn’t see the need to hire dedicated compliance personnel and mostly saw implementation of compliance programs as an unjustified expense. Even when compliance efforts were undertaken, the role of compliance officer was either assumed by the physician or was thrust onto an unsuspecting and untrained coder or office manager.

Follow Compliance Trends

The trend in federal law has certainly elevated the need for trained compliance professionals. Passage of the Fraud Enforcement and Recovery Act (FERA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the Patient Protection and Affordable Care Act (PPACA) have substantially increased government enforcement authority for false claims and privacy/security violations. Compliance efforts are no longer an option; they are a necessity. Also notable within PPACA is the authority for the secretary of the U.S. Department of Health and Human Services (HHS) to mandate implementation of formal compliance plans. Given this statutory authority, it is no longer a question of IF physician practices will be mandated to implement formal compliance programs, but WHEN. With these substantial changes in enforcement coupled with the looming mandate of formal compliance program implementation, there couldn’t be a better time to enhance your professional skills with formal compliance training and certification.

Compliance Know-how Can Improve Profit

Sooner or later, practices will have to bite the bullet and implement compliance programs. Compliance program implementation certainly involves a degree of cost going in; however, a surprising but often experienced outcome is an increased profit margin. The benefits can be measured both in the short and long term. Short-term profitability is measured in reduced claim denials, reduced expenses in claims processing (fewer re-submits and appeals), and improved collections. Such results are a by-product of risk analysis, which forces the practice to identify carrier-specific billing and reimbursement rules. Knowing these rules and being compliant with them will reduce incidents of claim denial due to errors in billing or documentation deficiencies. The educational component of a compliance program ensures all practice members are aware of any specific risks or problems so correction occurs in a timely fashion again, reducing incidents of non-payment or diminished payment.

The long-term impact to profitability is measured in terms of diminished post-payment risk. Having an effective compliance program will significantly reduce a practice’s potential of becoming the target of fraudulent conduct allegations, which are costly to defend.

Certify Compliance Skills for Today’s Job Market

The result of an increased emphasis on compliance is an increased need for trained compliance professionals. Because the most significant area of compliance risk is fraud and abuse (billing), coding professionals can easily fill these compliance positions with some additional training. Coding professionals are well-suited for the CPCO™ credential because they are:

Enhance Your Professional Compliance Status

Become a Certified Professional Compliance Officer (CPCO™) to boost your marketability in a regulatory environment.
• already familiar with carrier-specific coding and reimbursement rules;
• usually the individuals in a practice who are most concerned with compliance; and
• most suitable for taking the lead in their practice’s compliance efforts.

With the elevated enforcement climate, the pending mandate to implement an effective compliance program, and the benefits of effective compliance program implementation; no practice can afford to ignore compliance any longer. Compliance is no longer an “extra” obligation—it’s a primary responsibility. Coding professionals who enhance their professional skill set with compliance training and certification offered by AAPC will be well positioned to respond to the increasing need for certified compliance officers.

To find out more about the CPCO™ credential, go to the AAPC website at: www.aapc.com/certification/cpco.aspx.

Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CHCC, has a bachelor of science degree from the U.S. Military Academy, a juris doctorate degree from Concord Law School, is the president of Practice Masters, Inc., and the founding partner of Miscoe Health Law, LLC. He is a past member of AAPC’s National Advisory Board (NAB) and a current member of the Legal Advisory Board. He is admitted to the Bar in California and to practice law before the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. He has nearly 20 years of experience in health care coding and over 15 years as a coding and compliance expert testifying in civil and criminal cases. He is a national speaker and has been published in numerous national publications.

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An Answer to All Your Local Chapter Questions
Let the Local Chapter Handbook be your guide.

Each day the AAPC local chapter department receives a number of calls and e-mails from local chapter officers asking a myriad of questions. Often the questions could have been answered by simply referring to the Local Chapter Handbook. Once members agree to accept a position as an officer, they agree to “Comply with all requirements as outlined in the Local Chapter Handbook.”

It is important for every officer to read the handbook when he or she takes office and again when it is updated mid-year. It’s a good idea to have a hard copy or electronic version of it available at all local chapter meetings. This can be very helpful when members have question or even fellow officers have questions.

With the help of the AAPC local chapter department, the AAPC Chapter Association (AAPCCA) compiled a list of the most frequently asked questions and where to find the answers in the handbook.

Q1. What is required to keep our chapter in good standing?
A1. The list of requirements can be found in chapter 2, Local Chapter, section 4, Expectations of Local Chapter Officers:

4.1.1 Promote the AAPC and its mission on a local level.
4.1.2 Communicate all local concerns with the AAPC in a timely manner.
4.1.3 Submit the current Election Verification information within 30 days of elections.
4.1.4 Hold at least six (6) regular approved meetings per year where CEUs are offered.
4.1.5 Sponsor at least four (4) certification examinations each year, quarterly.
4.1.6 Abide by the rules of the Local Chapter Proctor Site Agreement found in Chapter 9 of this handbook.
4.1.7 Ensure appropriate use of chapter funds as outlined in the handbook.
4.1.8 Submit a Profit and Loss Statement for the preceding calendar year by January 15th of the following year.
4.1.9 Ensure that local chapter membership lists are used expressly for local chapter activities/business. It is recommended that officers not forward emails such as job openings to their members. This information should be communicated at a chapter meeting, through the chapter newsletter or on your individual AAPC local chapter forum.
4.1.10 Misuse of the chapter member list constitutes grounds for dismissal from office.
4.1.11 Encourage use of AAPC forums for networking purposes between chapter members.
4.1.12 To ensure the members’ privacy, officers should add chapter members’ email addresses to the blind copy line for any group email. The member list is available on the AAPC website and can be downloaded, copied and pasted into an email document.
4.1.13 Comply with all requirements as outlined in, but not limited to, the Local Chapter Handbook.

Q2. Can we charge a fee for chapter meetings?
A2. Yes. A nominal fee is allowed to cover expenses; however, a chapter is not to profit from attendance at local chapter meetings.

This can be found in chapter 13, Financials, section 8, Collection of Local Chapter Member Assessment:

8.1 “In as much as membership with AAPC automatically entitles members to attend local chapter meetings, local chapters should not charge local membership dues. It is our desire to enable members to participate without significant cost. However, we recognize the need to cover meeting costs. Therefore, if local chapter officers feel it is necessary to assess a fee for individual events to help cover expenses such as meals, special speakers, copies, room rental, etc., then a nominal fee may be assessed. Higher fees may be charged to non-AAPC members. Local chapters will collect these additional monies with no involvement from the AAPC.”

Q3. Can non-AAPC members attend meetings?
A3. Yes, but there is a limit to the number of meetings they are allowed to attend. The answer is found in chapter 7, Local Chapter Meetings, section 1, Attendance at Local Chapter Meetings:

1.3 “Non-AAPC members may attend up to three local chapter meetings before membership with AAPC is required.”

Q4. When will my local chapter meeting be approved?
A4. If the meeting is submitted online, the answer can be found in chapter 7, Local Chapter Meetings, section 9, Application for CEUs for Chapter Meetings:

9.5 “Requests for CEUs submitted online are typically approved by AAPC within 24 to 48 business hours.”

Q5. Does a seminar count as a meeting and what is the difference between a seminar and a meeting?
A5. No. A seminar does not count as a chapter meeting. Excellent involvement from the AAPC.

Excellent information regarding seminars and/or symposiums can be found in chapter 7, Local Chapter Meetings, section 13, Local Chapter Seminars:

13.1 “Local chapters may plan and conduct seminars or symposiums. The purpose of these activities is to provide extended educational opportunities for the local members beyond the regular chapter meetings, at a reasonable cost to members. The AAPC is available to provide reference support.”
13.2 “Seminars or symposiums are presented under the direction of the local chapter.”
13.3 “The local chapter is responsible for all seminar-related expenses. Any income generated from the seminar is retained by the local chapter for their use. Be aware, any excess profit not spent by the end of the year may be subject to tax obligation to the chapter.”

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Q6. How does chapter reimbursement work?

A6. There are two types of reimbursement for which chapters may be eligible. To receive reimbursement, the chapter must submit the Election Verification information for their current officers and the Profit and Loss Statement for the previous year. The specifics on reimbursement can be found in chapter 13, Financials, sections 11-12:

11.2.2 “The Local Chapter Department will reimburse $10 for each examinee as documented on the exam sign-in sheet.”

11.3 “Reimbursement checks will be made payable to the local chapter and be deposited into the local chapter bank account on a quarterly basis.”

12.3 “The local Treasurer submits the attendance sheets to the AAPC at the end of each quarter. To ensure timely reimbursement, the reimbursement requests should be submitted within 15 days following the end of the quarter (April 15th, July 15th, October 15th, and January 15th).”

12.4 “Reimbursements will be made payable to the local chapter and be deposited into the local chapter bank account on a quarterly basis.”

Q7. Who can proctor an exam?

A7. Information on proctoring can be found in several locations in the handbook. The best reference for this question is chapter 9, Proctor AAPC Certification Examinations, section 2, Scheduling Examination Dates:

2.7 “There must be two proctors assigned to administer every examination. The first proctor must be a certified local chapter officer. The second proctor must be an AAPC member. Both proctors must be current AAPC members in good standing. If additional proctors are needed due to the number of attendees, the same requirements apply.”

Q8. Can a CPC-A® be an officer?

A8. Yes. A CPC-A® can be an officer. The president, president-elect, and education officer must hold a credential. The CPC-A® designation is a recognized credential. See chapter 4, Requirements of Local Chapter Officers, section 1, Expectations of Chapter Officers:

1.3 “President, President-elect and Education Officer must hold an AAPC credential.”

1.4 “Other chapter officers are encouraged to obtain AAPC certification by the beginning of their terms in office.”

Q9. Who submits the Verification of Election form online?

A9. It is the responsibility of the president-elect to complete the Verification of Election form. This information can be found in chapter 5, Local Chapter Officer Responsibilities, section 4, President Elect:

4.7 “Complete the Election Verification information on the AAPC website within 30 days of officer election.”

Q10. When does a chapter need to submit the Profit and Loss (P&L) Statement?

A10. It must be submitted by Jan. 15 of the following year. See chapter 2, Local Chapters, section 4, Expectations of Local Chapter Officers:

4.1.8 “Submit a Profit and Loss Statement for the preceding calendar year by January 15th of the following year.”

Q11. What do we do if an officer resigns?

A11. The steps that need to be taken in this situation are outlined in chapter 5, Local Chapter Officer Responsibilities, section 12, Change of Officers:

12.1 “In the event of a change of officer in the middle of the term, the current officers may appoint a new officer.”

12.1.1 “The resigning officer should send a resignation letter to the AAPC and to the local chapter President.”

12.2 “The President or the President-elect should obtain the proper signature of the newly appointed officer and submit a Change of Officers form to the AAPC within 10 days of the acceptance.”

12.3 “If the resigning officer is a signer on the chapter bank account, the current chapter officers must ensure the resigning officer’s signature is removed and the new officer’s signature is added.”

Q12. What can a chapter do if it feels an officer is not performing the duties of the position he or she is elected to do?

A12. You need to contact the AAPC local chapter department to make them aware of the situation and allow them to work with you and the officer. See chapter 5, Local Chapter Officer Responsibilities, section 14, Removal From an Office:

14.1 “A local chapter may not take action without obtaining authorization from the AAPC Local Chapter Department and the AAPCCA. Once authorization is obtained, a local chapter officer may be removed from office by a majority vote of AAPC chapter members present at a regularly scheduled meeting.”

Q13. How can a chapter spend funds appropriately?

A13. This answer can be found in chapter 13, Financials, section 2, Accounting. There is a great deal of information in the handbook regarding the usage of chapter funds. Here is one of the guidelines:

2.1 “Local chapters may use chapter funds to cover expenses including, but not limited to, the payment of local event meeting rooms, speakers, handouts, refreshments, promotion of the local chapter, and other general chapter expenses.”

Q14. How can I find the Local Chapter Handbook?

A14. To find the Local Chapter Handbook, officers need to log onto the AAPC website. When signed in, select the “My AAPC” tab, and then select the “My Chapter” link. The “My Chapter” page has a menu on the left side of the screen with a link to the “Local Chapter Handbook.” Now, take some time to read it.

Remember: Knowledge is power! ✨

Angela Jordan, CPC, serves on the AAPCCA board of directors and is manager of coding and compliance for EvolveMD by WHN Lenxa, Kan. She has over 20 years experience in health care. Her primary focus is EHR training, provider education and documentation audits. Angela received her CPC in 2000 and has since been active in her local chapter. Previously, she was honored by her peers as Coder of the Year, and Networker of the Year by the Kansas City chapter.
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