2010 Member of the Year

Maryann Palmeter, CPC, CENTC
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On the Cover: AAPC’s 2010 Member of the Year, Maryann C. Palmeter, CPC, CENTC, director of physician billing compliance at University of Florida Jacksonville Healthcare, Inc., found that the secret to happiness is the three Cs: coding, compliance, and cows. Cover photo by Jon. M. Fletcher (www.jonmfletcher.com).
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In my 30 plus years in this industry, I’ve come across a diverse group of personality types, each bringing different strengths and experiences to our field and organization. AAPC is full of outstanding coders, some of whom are recognized nationally by their chapters as officers or by their peers. Let’s acknowledge the characteristics of these extraordinary coders who help to make AAPC an amazing organization.

Our Outstanding Membership
Many of you find satisfaction in knowing you do a great job. You take pride in doing your personal best by:

• Networking to find the correct answer or to provide coding expertise to help fellow coders.
• Promoting our profession and its importance in capturing correct payment for physician services.
• Keeping abreast of coding updates and changing guidelines, and quickly sharing those with others.
• Educating providers with integrity to “do the right thing” when selecting codes, even if there is resistance.
• Spreading coding insight through local chapters, seminars, mentoring, and other teaching opportunities.

These are some characteristics I’ve seen in our members that are exceptional:

• Pulling together in times of crisis, helping colleagues when they need it.
• Supporting each other through local chapters, mentoring, AAPC forums, and e-mail.
• Developing life-long friendships.
• Volunteering time to be local or national leaders.
• Dedicating selflessly and tirelessly to promote coding excellence to the highest degree.
• Stopping at nothing to improve coding and coders.
• Making coding fun, even in challenging situations.

Recognize Our Every Day Heroes
This month we honor our Member of the Year and the 2011-2012 National Advisory Board (NAB). These members, along with all those dedicated to the success of our local chapters, help us all advance coding as a valuable profession.

You can show another coder that you recognize and appreciate his or her hard work and dedication. On a national level, one way is to nominate in the late fall an individual for the AAPC Member of the Year Award. Coding Edge is another good venue to recognize fellow coders’ accomplishments. You can acknowledge coders or chapters who do extraordinary things by sending your stories to kudos@aapc.com; or suggest one of our unsung heroes to feature as a Minute with a Member by sending the name of the member you’d like to highlight to michelle.dick@aapc.com.

On the local level, you can work through your chapter or take a moment to tell your colleague how important his or her contribution is to you.

When you notice a member doing something extraordinary, take the time to acknowledge it and personally thank that individual, such as Maryann C. Palmeter, CPC, CENTC. Thank you, Maryann, for being an outstanding member in 2010.
Latest CPT® 2011 Errata

On April 1, updates were released by the American Medical Association (AMA) for CPT®. Update your CPT® books accordingly for the July 1 implementation date.

As used in the CPT® code book, a bullet (●) precedes code additions, a triangle/delta symbol (▲) precedes revised codes, a number sign (#) precedes resequenced codes, and a circle (○) precedes reinstated codes. Changes are listed with underlines for added text and strikethroughs for deleted text.

CPT® Changes

There are 12 pages of changes. Here are some of the updates:

Surgery - Digestive System

Delete the parenthetical note following 47490, referencing radiological supervision and interpretation; use 75989 because code 47490 has been revised and is now a bundled service.

Pathology and Laboratory Chemistry

● 87502 Influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, first 2 types of sub-types

Appendix B

Code 99365 has been deleted from Appendix B because it’s not an active CPT® code.

Code 93268 has been revised to continue inclusion of the phrase "24-hour attended monitoring:"]

▲ 93268 External Wearable patient and, when performed, auto-activated electrocardiographic rhythm derived event recording with remote download capability up to 30 days, 24-hour attended monitoring, per 30-day period of time; includes transmission, physician review and interpretation

ASCII Files

#● 29914 Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)

#● 29915 Arthroscopy, hip, subtalar joint, surgical; with acetabuloplasty (ie, treatment of pincer lesion)

#● 29916 Arthroscopy, hip, subtalar joint, surgical; with labral repair

There have been many changes, as well, to short descriptions, parenthetical notes, and to codes with typos. The complete list of changes are available on the AMA website at: www.ama-assn.org/resources/doc/cpt/cpt-2011-corrections.pdf.

Category II Code Updates

The following Category II codes have been added to the Category II coding set since the printing of the 2011 CPT® code book. Append these code changes to your 2011 CPT® code books. The code changes will first appear in CPT® 2012.

Patient Management

● 0550F Cytopathology report on routine nongynecologic specimen finalized within two working days of accession date (PATH)

● 0551F Cytopathology report on nongynecologic specimen with documentation that the specimen was non-routine (PATH)

Patient History

1125F Pain severity quantified; pain present (COA) (ONC)

1126F Pain severity quantified; no pain present (COA) (ONC)

(Codes 1127F and 1128F have been deleted)

○ 1127F New episode for condition (NMA – No Measure Associated)

○ 1128F Subsequent episode for condition (NMA – No Measure Associated)

Diagnostic/Screening Processes or Results

● 3125F Esophageal biopsy report with statement about dysplasia (present, absent, or indefinite) (PATH)

● 3267F Pathology report includes pT category, pN category, Gleason score and statement about margin status (PATH)

● 3394F Quantitative HER2 Immunohistochemistry (IHC) evaluation of breast cancer consistent with the scoring system defined in the ASCO/CAP guidelines (PATH)

● 3395F Quantitative non-HER2 Immunohistochemistry (IHC) evaluation of breast cancer (eg, testing for estrogen or progesterone receptors [ER/PR]) performed (PATH)

Patient Safety

● 6100F Timeout to verify correct patient, correct site, and correct procedure, documented (PATH)

The list of Category II code section changes can be downloaded from the AMA website at: www.ama-assn.org/resources/doc/cpt/cpt-cat2-codes.pdf.

To view the complete CPT® Category II Codes Alphabetical Clinical Topics Listing changes go to: www.ama-assn.org/resources/doc/cpt/cpt-cat2-codes-alpha-listing-clinical-topics.pdf.
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Modifier changes:
• One new — Modifier 33
• One deleted
• Four revised

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This past year, I found myself contemplating the achievements and not so great moments of my life and career. At the risk of sounding full of myself, I am proud of what I have accomplished, but I admittedly have had my share of those “What did I get myself into this time?” or “There is no way I can take on one more task” moments. I have found this to be a common lament among many of our peers. Why do we do what we do? And where do we find the reserves needed to continue doing it?

Hal Has the Answer

I recently attended a managers’ training session during which we were asked to watch a video presentation. In this presentation, Hal, the commentator, told us about his uncle who went about his daily tasks, not trying to make a difference, but instead just seeing what needed to be accomplished for others, and contributing to the effort to meet those needs. As he went about his daily tasks, he was happy—happy to help, happy to contribute. He took joy in helping others accomplish a goal that benefited the team as a whole, and it didn’t matter that it may not have been his personal goal. By contributing, even in small ways, Hal’s uncle was making a difference.

Giving to Help Others

Making a difference does not have to be a monumental task, just a contribution of one’s time, knowledge, skills, or energy. All of us enjoy helping when we have the time, but how many of us make the time? It’s the individual who makes the time and who truly finds joy in contributing, regardless of the personal cost in his or her time and energy, who has found the answer. Such an individual renews and recharges by contributing to the greater good. AAPC has an award for such an individual.

AAPC Member of the Year

Each year the National Advisory Board (NAB) selects a member to recognize his or her outstanding contributions, leadership, and achievements in service to our fellow AAPC members. Earning this award requires significant participation and support of AAPC and member activities. Through his or her actions, the member advances the mission, goals, and purpose of AAPC and positively affects AAPC’s programs, activities, and services.

Your 2010 Member of the Year has met these requirements abundantly. Her efforts and time given to others has made a difference in the lives of many of our members. She is an active member whose contributions and achievements include:

- Working with neighboring chapters to ensure numerous opportunities for networking and learning;
- Providing educational opportunities by frequently presenting at local chapter meetings and seminars. Her topics include: a virtual tour of the AAPC website, evaluation and management services auditing, immunization billing for Medicare Part B, and diagnosis Pictionary;
- Acting as a resource to members by addressing coding and compliance questions from members via the AAPC Forum, e-mail, Facebook, etc.;
- Lending her considerable knowledge and experience about coding and compliance to various publications and projects, including Part B News, and the AAPC CENTC™ specialty credential exam;
- Regularly sharing AAPC members’ issues and concerns with the AAPC Chapter Association (AAPCCA) and national office; and
- Playing a key role in the coordination of volunteers for the 2010 Jacksonville National Conference by organizing volunteers and their schedules.

With 27 years of experience, she contributes to the coding profession by providing multi-specialty coding and compliance advice for the physicians, residents, non-physician practitioners, and coding and billing staff at the University of Florida Jacksonville Healthcare, Inc., where she is employed. Please join the NAB and myself in congratulating the 2010 AAPC Member of the Year, Maryanne Palmeter, CPC, CENTC.

Best Wishes,
Cynthia Stewart,
CPC, CPC-H, CPMA, CPC-I, CCS-P
President, National Advisory Board
In Revascularization Hierarchy, Atherectomy Trumps Stent Placement

I would like to provide some clarification regarding recent CPT® code changes for revascularization services.

The February article, “Master the Significant Revisions to 2011 Vascular Codes,” (page 34), states that lower extremity revascularization codes follow a hierarchy, “in which stent placement with atherectomy is considered the highest level of intervention, followed by stent placement, atherectomy, and then angioplasty.” Rather, for lower extremities, the hierarchy is:

- stent placement with atherectomy
- atherectomy
- stent placement
- angioplasty

As stated in the original article, angioplasty is bundled to all lower extremity revascularization codes introduced to CPT® for 2011.

On page 35, when discussing the tibial/peroneal territory, the article states that a hierarchy of codes again applies, in which “stent placement with atherectomy supersedes stent placement without atherectomy, which supersedes atherectomy, which supersedes angioplasty alone.” Instead, the hierarchy is:

- stent placement with atherectomy
- atherectomy
- stent placement
- angioplasty

Once again, angioplasty is included in all interventions, if performed.

David Zielske, MD, CIRCC, CPC-H, CCC, CCS, RCC

Canalith Repositioning (95992) Gets Paid in 2011

Barbara Cobuzzi’s March 2011 article, “CPT® 2011 Covers the Latest in ENT Procedures,” (pages 14-16) was much appreciated. There is another ear, nose, and throat (ENT)-related change for 2011; however, this one pertains not to CPT®, but to Medicare billing and payment for physicians and therapists.

In the 2011 final rule from the Centers for Medicare & Medicaid Services (CMS), CPT® code 95992 Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day had a status change from “I” to “A.” To understand the importance of this change, some history is needed.

Canalith repositioning, also known as the Epley maneuver or Semont maneuver, is performed to alleviate the symptoms of benign paroxysmal positional vertigo (BPPV). It is performed either by physicians or physical therapists, after careful evaluation. Code 95992 is untimed and you may report a single unit per calendar day.

Code 95992 was introduced in 2009, and initially was given a status of “B,” or bundled (payment for covered services are always bundled into payment for other services not specified). The logic was that, for physicians, the service would be bundled with and paid through the evaluation and management (E/M) service it would accompany.

Therapists, however, are not allowed to bill E/M services, and were concerned that they would not receive payment for canalith repositioning due to the bundled status. CMS, therefore, made a clarification in Change Request (CR) 6397, Transmittal R1691CP and MM6397, that therapists who provide these services should report 97112 Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities for canalith repositioning. Because 97112 is a timed code, it may be billed with multiple units based on the defined Medicare 15 minute billing rule for therapy timed codes.

In the 2010 rule, to provide further clarification, 95992 was changed to status “I,” or invalid (not recognized for payment under Medicare), thereby eliminating the bundling issue for physicians (who would not be paid for the service, except as part of an E/M). Therapists would continue to bill 97112 for canalith repositioning.

CMS received many comments regarding its policy toward 95992, and they were made more aware of the distinct and separate nature of this procedure. Stakeholders requested that 95992 be recognized for payment in a manner similar to that for other minor procedures. In response, CMS defined 95992 for 2011 as an “A” (active) code (separately payable under Physician Fee Schedule [PFS] if covered). Canalith repositioning (reported with 95992) may be furnished by a physician or therapist under a therapy plan of care (with modifier GP). Code 95992 is designated as a “sometimes therapy” code and is not subject to the new multiple procedure payment reduction (MPPR) rule, which only applies to “always therapy” codes.

Therapists will receive 100 percent of the practice expense (PE) payment for 95992, but no longer may claim multiple code units (using either 97112 or 95992) to report canalith repositioning. Instead, therapists may report 95992 only once per day, without regard to the length of the procedure. With recovery audit contractors (RACs) looking at timed and untimed codes more closely, the therapy community must be more vigilant in their education regarding timed and untimed codes and the distinct change in their billing pattern for this procedure.

Lynn Berry, PT, CPC
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You may think there isn’t a need for you to attend local chapter meetings because you earn all your CEUs from Coding Edge or your employer pays for other CEU sources. If that’s the case, perhaps you’re missing the main reasons for attending and being active in your local AAPC chapter.

Networking is a substantial benefit to attending meetings. Whether you’re a new coder looking for a position or an experienced coder looking for a change, attending local chapter meetings enables you to make new contacts with employed coders, coding supervisors, and managers who are potential employers.

Yes, earning CEUs and networking are both great reasons for attending local chapter meetings, but they’re not the only reasons.

More than CEUs and Networking

There are other reasons to support your local chapter that often go unmentioned or unrecognized.

Education—There are a wide variety of subjects to learn about in this business. All too often, though, coders develop tunnel vision and don’t learn beyond their specialty. While it’s true that the information you receive at any particular meeting may not directly relate to your present position’s day-to-day coding, your current situation could change. In the event you are let go or decide to move on, being a well-rounded coder will make the transition much easier.

Having Fun—Never underestimate the importance of relaxing and enjoying the company of other coders. My local chapter schedules coding games for two or three meetings per year. The games are interactive so members get to know each other while learning. Whether the game focuses on terminology, anatomy, coding taboos, Coding Jeopardy, or any other interactive session, there is always something new to learn. Even if you come away from a meeting with only one new piece of knowledge, that meeting was well worth attending.

Every December consider stepping away from the educational aspect of coding and just have fun. My chapter has a well-attended, annual Christmas party where we just eat, talk, laugh, and enjoy each other’s company.

Helping the Community—My chapter presents two Saturday workshops each year, one in the spring and another in the fall. At the fall workshop, we give workshop attendees the opportunity to purchase raffle tickets for a handmade Texas Tech blanket (made by yours truly) as well as other donated items. Some items are donated by other officers or chapter members and some are donated by local merchants. Each item is raffled independently. The money we make from raffling these donated items is then presented to a local children’s charity. One year at the fall workshop we put out a Susan G. Komen donation can, and our membership was very generous in their (voluntary) donations. At our yearly Christmas party, members can bring an unwrapped toy for underprivileged children in our community. I am very proud to say that, even though this also is voluntary, absolutely no chapter member has ever attended our party empty handed.

Reasons to Be a Chapter Officer

Is being a local chapter officer a lot of work? Absolutely. Is it worth it? Again, absolutely!

I’ve served for several years in various local chapter positions, and the experiences have been invaluable to me in many ways. As a chapter officer you sharpen your skills in time management, supervision, planning, and coordinating events, budget issues, public speaking, and sometimes psychology. After all, you cannot lead a group without using personnel management, counseling, and human resources skills.

During my years serving my local chapter, I have grown more confident in my own abilities and mentor skills. I have seen my chapter grow from 12 or 15 attendees on a good night to our present average
of 45 to 50. The satisfaction from that alone has made the time and effort of leadership well worthwhile.

Serve Without Being an Officer

There are many ways to serve your chapter, even if you are not an officer. Supporting your chapter by regular attendance is vital. If you would like to do more, you might volunteer to do a presentation on your specialty or a subject of particular interest to you. This is extremely helpful to the officers in planning meetings and offering programs for CEUs to the chapter. It also builds self confidence and hones your public speaking and organizational skills.

You also could ask your provider to speak at a chapter meeting. Remember: Membership has access to multiple providers, multiple specialties, and multiple areas of health care. Because officers are limited to their professional circle, one of their biggest challenges is obtaining speakers and programs for monthly meetings. You might also present any ideas you might have for subjects of interest and coding discussions; or volunteer to participate in a panel discussion for a meeting.

Even coming early to help set up for the meeting and/or staying a little late to help straighten up the meeting room would be appreciated by your chapter officers.

I strongly urge all AAPC members to join and participate in their local AAPC chapters. Get involved and stay involved. There will be times when you think you’re just too tired to attend a meeting, but try to attend anyway. You will come away feeling better and even not quite so tired. Just remember: The rewards far outweigh the sacrifices. Committing to your chapter is something you will never regret.

Sylvia Adamcik, CPC, CPC-I, CCS-P, is unit manager for the Medical Practice Income Plan for Texas Tech University Health Sciences Center School of Medicine with over 25 years of experience in health care. She is a member of her local AAPC chapter serving as president, and was named a 2009 Region V finalist for Coder of the Year.

Never underestimate the importance of relaxing and enjoying the company of other coders.

It’s that time of year again for May MAYnia!

So “Ride the Wave” to your AAPC Local Chapter meeting in the month of May!

Attend your AAPC local chapter meeting this May to:

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

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

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

Find the May MAYnia Local Chapter meeting near you by visiting www.aapc.com/MAYNIA.
Modifier 33 Arrives Quietly
But Packs a Punch

Use this new CPT® modifier to help payers identify preventive services.

Modifier 33, effective since Jan. 1, 2011, slipped through the door quietly and unnoticed, like a neighbor’s cat. The new modifier is not in the CPT® 2011 Professional Edition book, but was announced at the American Medical Association’s (AMA) CPT® Symposium last November, after the CPT® manual had been published. Officially, the modifier’s language is:

**Modifier 33 - Preventive Service: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, Preventive Service, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.**

**Part of Health Reform**

Modifier 33 supports a major part of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA), which requires health care insurers (including commercial insurers) to cover certain preventive services and immunizations without passing the cost on to the provider or patient. Specifically, the AMA’s CPT® Assistant (December 2010, vol. 10, 12) instructs payers not to impose cost sharing on an office visit if the primary reason for the visit is to receive preventive services. Cost sharing is permitted for an office visit when it is billed separately from the covered preventive services, and the primary purpose of the office visit is not preventive. Payers also may impose cost sharing (or choose not to provide coverage) if the provider is out-of-network, or for services not included in the law.

Modifier 33 allows a provider to identify a service as preventive under ACA, and to indicate that cost sharing does not apply. You may append the modifier to CPT® or HCPCS Level II codes when:

- The primary reason for the visit was preventive, and you wish to mark the service as preventive so payer processing systems will notice it as such.
- The primary visit was preventive, but resulted in a therapeutic service, such as when a screening colonoscopy (45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)) or G0104 Colorectal cancer screening; flexible sigmoidoscopy becomes a polypectomy (45383 Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyps, or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique).
- Multiple preventive services are provided the same day, and you wish to identify each preventive service that day.

You don’t need modifier 33 for inherently preventive services; for example: a screening mammography (77057 Screening mammography, bilateral (2-view film study of each breast)), screening colonoscopy (45378 or G0104), or prostate screening with prostate specific antigen test (PSA) (G0103 Prostate cancer screening; prostate specific antigen test (PSA)). If the code description says “screening,” that’s a pretty good indication you don’t need modifier 33. Inherently preventive services also include immunizations for routine use in children, adolescents, and adults, as recognized by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). One example of such an immunization is the measles, mumps, and rubella (MMR) shot (90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use).

Payers may implement this policy as new coverage is established, or as existing coverage is renewed. A review of payers’ policy announcements indicates they are accepting modifier 33. The first indication of federal implementation came in March, when version 12.1 of the integrated Outpatient Code Editor (I/OCE) included the addition of an edit that acknowledges modifier 33. Providers and payers use the I/OCE application to manage the billing of outpatient prospective payment system (OPPS) services. Outpatient hospital services and ambulatory surgical centers (ASC) use OPPS, billing through CPT® and HCPCS Level II ambulatory patient categories (APCs).

**Modifiers 33 and PT**

Modifier PT Colorectal cancer screening test; converted to diagnostic test or other procedure also is new for 2011. When a patient is scheduled for a G0104, G0105 Colorectal cancer screening; colonoscopy on individual at high risk, or G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk, but a positive finding changes the procedure to a diagnostic colonoscopy, Medicare will waive the patient deductible for the diagnostic colonoscopy performed on the same day as a scheduled screening colonoscopy. However, patients are responsible for the copay for the diagnostic colonoscopy.
A review of payers’ policy announcements indicates they are accepting modifier 33.

What’s the bottom line when performing a screening colonoscopy that becomes diagnostic? If the payer is Medicare, use modifier PT. If the payer is commercial, use modifier 33.

**What Qualifies?**

Expected confusion about modifier 33 prompted the AMA and CMS to outline when it can be used. The new modifier is applicable for identifying preventive services without cost sharing in four categories:

- Services rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF) as posted annually on the Agency for Healthcare Research and Quality’s website: [www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm](http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)
- Immunizations for routine use in children, adolescents, and adults as recommended by the ACIP of the CDC
- Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics), as supported by the Health Resources and Services Administration
- Preventive care and screenings provided for women (not included in the USPSTF recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration

Services with “A” or “B” ratings by the USPSTF are services that are recommended to be offered or provided. Services graded with an “A” rating have been judged to have a high certainty of a substantial net benefit. Services graded with a “B” rating have been judged to have a high certainty of moderate to substantial net benefit.

For more information about modifier 33, contact your payer. Remember that implementation will differ for your patients as their health plans renew.

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

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Evaluation and management (E/M) checklists are effective timesavers, but they may lend themselves to documentation shortcuts that won’t stand up to the scrutiny of an audit. Consider Figure A.

This example, based on actual documentation sent by an AAPC member, came with a question:

The doctor’s template for the exam has boxes with normal and abnormal. When the dermatologists do the exam, they draw a single line through normal findings and abnormal findings. From an auditing standpoint, is this the proper way to do the exam? Or, should the provider check each individual box for the normal or abnormal findings?

The short answers are “No” (this is not the proper way to document the exam), and “Yes” (the providers should check each box individually). To explain those answers, let’s dig deeper.

**The Good, the Bad, and the Ugly**

The documentation in our example has its good points. For instance:

- Diagrams for pertinent positives (as are used in Figure A) are an excellent addition; however, the diagrams should correlate specifically with abnormal findings as marked on the template grid.
- The examiner uses standard medical abbreviations (the abbreviation “LN2” is known to dermatology coders as liquid nitrogen destruction). Note that the Centers for Medicare & Medicaid Services (CMS) requires a copy of abbreviations or “keys” used in the documentation, if they are other than standard medical abbreviations.

What’s bad about this documentation is that it lacks specificity. According to CMS, “A brief statement or notation indicating ‘negative’ or ‘normal’ is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).” But the same guidelines also stipulate:

- An entire organ system should not be documented with a statement such as “negative.”
- Specific abnormal and relevant negative examination findings of the affected or symptomatic body area(s) or organ system(s) should be documented.
- A notation of “abnormal” without elaboration is not sufficient.

A single line drawn through several boxes, with a one-word explanation (“nodules”) to designate abnormal findings does not meet the CMS requirement: “abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.” What does “nodules” mean? What shape are they? Flat? Round? How big are they? Are they painful? Do they bleed or itch?

The documentation may have seemed sufficient to the documenting provider at the time of the exam, but he or she probably couldn’t make sense of it six months later. Anyone other than the documenting provider would have a hard time making sense of it at any time. An auditor even might interpret a single line drawn through several boxes as a “strikethrough,” indicating that no exam was performed in these areas. Any illegible or confusing documentation could be considered invalid.

What’s truly ugly in our example is that no E/M service or medical necessity for such a service is documented. There is no assessment or plan with a diagnosis. And, there is no description of the “nodules” as benign, malignant, or premalignant to support appropriate CPT® coding for lesion destruction.

**Bold and Beautiful Documentation**

Now, let’s consider Figure B, which shows an example of an E/M checklist documented correctly.

In this example, each relevant checkbox is marked individually to in-
What’s truly ugly in our example is that no E/M service or medical necessity for such a service is documented.

dicate positive or negative findings, and abnormal findings are elaborated in detail. The lesions are identified as premalignant actinic keratosis, the number and size are documented, locations are shown in the accompanying diagram, and LN2 is described as the method of destruction. This level of documentation supports destruction of the lesions using codes from the 17000 series of CPT® (e.g., 17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (eg, actinic keratoses); first lesion for the initial lesion and +17003 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) x 4 for the four lesions beyond the first).

A significant E/M service also is documented in its entirety, and may be reported separately (e.g., 99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history, An expanded problem focused examination; Straightforward medical decision making). Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service would be appended to indicate that the E/M service is distinct from the lesion destruction at the same encounter.

**Sidebar**

**Figure B**

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To indicate positive or negative findings, and abnormal findings are elaborated in detail. The lesions are identified as premalignant actinic keratosis, the number and size are documented, locations are shown in the accompanying diagram, and LN2 is described as the method of destruction. This level of documentation supports destruction of the lesions using codes from the 17000 series of CPT® (e.g., 17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (eg, actinic keratoses); first lesion for the initial lesion and +17003 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion) x 4 for the four lesions beyond the first).

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**Template Documentation Points to Ponder**

CMS allows providers to use documentation templates, but the resulting note—whether paper or electronic—must be specific to the patient and the service rendered. To ensure compliant use of templates, consider these basic guidelines as provided by Wisconsin Physicians Service Insurance Corporation (WPS) Medicare:

- Either the ancillary staff or the patient may complete the review of systems (ROS) and the past family social history (PFSH) as part of the template, checklist, and/or electronic health record (EHR). The provider must notate his or her review of the information. Additions to the file or confirming notations substantiate the provider’s review.
- The provider may use an ROS or PFSH from a previous encounter. The provider must notate the date of the earlier ROS or PFSH and review all elements of the previous encounter noting any changes or elements not reviewed.
- The billing provider must perform the history of present illness (HPI). The ancillary staff cannot collect this information and enter it into the medical record with the provider only signing or acknowledging they read the notation.
- Documentation must clearly define the examination and findings to support the level of service submitted.
- A brief statement or notation of “negative” or “normal” is sufficient to document normal findings.
- The provider must document any specific and pertinent abnormal and relevant negative findings of the affected or symptomatic body area(s) or organ system(s). A notation of “abnormal” without elaboration is insufficient documentation.
- The provider must describe any abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ(s) systems.
- Forward a copy of abbreviations or “keys” used in the document if these are other than standard medical abbreviations.
- Signature requirements do not change with the use of templates, checklists, and/or EHRs. The documentation must show a legible identifier of the provider. You can find more information on the signature requirements in addition to attestation statements in the CMS *Internet-only Manuals* (IOM), publication 100-08, chapter 3, section 3.4.1.1.D.
- Providers should be wary of templates that have pre-printed information indicating certain “comprehensive” level services were performed. Documentation for each encounter must be specific to that encounter.
Whatever your tactic, the message must be loud and clear: Using a template or checklist (whether paper or electronic) is no excuse for skipping documentation details.

**The Coder’s Role**

Coders must educate physicians about documentation requirements. Show physicians the CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management (E/M) Services, and explain the level of detail necessary to report CPT® codes with accuracy. For instance, you could show the physician CPT® descriptors that specify location, size, or pathology (benign, malignant, etc.) as a requirement to assign codes. If all else fails, remember: Money talks. Demonstrate how missing documentation can lead to undercoding, lost revenue, and possible repayments, fines, or worse in the event of an audit. Whatever your tactic, the message must be loud and clear: Using a template or checklist (whether paper or electronic) is no excuse for skipping documentation details.

**Note:** Identifying information has been removed from all examples in this article, as per the Health Insurance Portability and Accountability Act (HIPAA) requirements; however, according to CMS guidelines, a provider signature is mandatory when using templates, checklists, and/or EHRs—just as it is when using other types of documentation.

**Sources:**


Peggy Stilley, CPC, CPMA, CPC-I, COB-GC, ACS-OB, is director of Auditing Services, AAPC Physician Services (AAPCPS). She has more than 30 years of experience in the health care industry. She is a national speaker and has presented for The Coding Institute, Ingenix, and Medical Business Institute, as well as for AAPC’s national conferences, workshops, and webinars, and has published articles on coding, billing, and practice management. She has served as president and membership officer in her local chapter.

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Next Step in ED Leveling: Evaluation Methodologies

Part 2: Once you’ve evaluated performance, refer to the four most frequently used leveling methods.

In “Evaluate Your Performance When ED Leveling” (January 2011 Coding Edge, pages 46-48), we discussed methods to determine whether your emergency department (ED) levels are appropriate based on Outpatient Prospective Payment System (OPPS) guidelines. We also noted that the 1995 and 1997 Documentation Guidelines for Evaluation and Management (E/M) Services do not apply to facility-side ED coding. Instead, the Centers for Medicare & Medicaid Services (CMS) directs hospitals to develop guidelines according to general recommendations, including:

- **Follow the intent of the CPT® code descriptor:** CMS is looking for higher E/M levels based on increased hospital services.
- **Base levels on hospital facility resources, not physician services:** As such, the use of physician E/M guidelines is inappropriate.
- **Guidelines should not facilitate upcoding:** Hospital leveling guidelines should not encourage coding not supported by documentation.

The lack of specific ED leveling guidelines has resulted in a proliferation of ED facility leveling methodologies. The four methods we’ve reviewed and found to be used most frequently are:

- Point Systems
- Matrices
- American College of Emergency Physicians® (ACEP) Method
- Commercial Hybrid Systems

Here is a description and analysis of each methodology.

**Point Systems**

Using a point system methodology, points are assigned for services, procedures, and hospital resources used by hospital employees, particularly nurses in the ED. Point values typically increase as the intensity of the services, procedures, time, and resources used increase. Usually, points are assigned for changes in patient status, such as “admit” or “transfer,” because of the hospital resources used in completing these changes.

The sample shown in Table 1 is relatively simple, with only four possible point values for hospital or nurse services: five, 10, 15, or 20. An example of a five point service is application of a Steri-Strip or a sling by hospital personnel, such as a nurse or technician, but not by a physician (because this is part of ED professional coding). A 10-point service might be blood pressure (BP) monitoring, providing emotional support, or accompanying a patient to lab or radiology. A 15-point service might be an intravenous (IV)-insertion, or pelvic exam. A 20-point service is reserved for the most resource- and time-driven services, such as admit to intensive care unit (ICU), assist with newborn care, or restraining/managing a combative patient.

The coding methodology is simple. The coder identifies these services on the ED chart and assigns the appropriate number of points for each service, procedure, etc. The coder then adds the total points, and follows level guidelines based on the total points. In our example, if points exceed 60, 99283 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity is assigned; if they exceed 100, 99285 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehen-
Facility examination; and Medical decision making of high complexity is assigned.

**Analysis**

For a point system to work properly, it is critical that all possible ED hospital services, procedures, and resources used are identified and itemized. Please note our example is limited. You will need to devise a method for assigning fair relative weight to each service to achieve an accurate point system. If your point system results in either very low or very high acuity coding (See “Evaluate Your Performance When ED Leveling,” referenced above), review the point system methodology.

Point systems are relatively easy to use and don’t require a strong coding background, but there can be a number of issues. The first is simple math. Correctly adding the points is crucial to getting the levels correct. Incorrectly adding or identifying the elements that have points can result in undercoding. Point systems also typically don’t weigh in coding issues such as severity of presenting problem. The result is a rote method that has very little to do with coding, and doesn’t always account for chief complaint and the resulting work and resources required to treat the patient.

### Table 1: The Point System

<table>
<thead>
<tr>
<th>Points</th>
<th>5 Points</th>
<th>10 Points</th>
<th>15 Points</th>
<th>20 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Assessment</td>
<td>BP Monitoring</td>
<td>Pelvic Exam</td>
<td>Admit ICU/CCU</td>
<td></td>
</tr>
<tr>
<td>Wound Cleanse Simple</td>
<td>Apply Clavicle Strap</td>
<td>Transport to ICU</td>
<td>Restraints Apply/Monitor</td>
<td></td>
</tr>
<tr>
<td>Topical Meds</td>
<td>Foley Cath Simple</td>
<td>Enema/Disimpaction</td>
<td>Cardiac/Thrombolytic Agents</td>
<td></td>
</tr>
<tr>
<td>Ace Wrap</td>
<td>Emotional Support</td>
<td>Multiple VS Checks</td>
<td>Rape Exam</td>
<td></td>
</tr>
<tr>
<td>Urine Dip</td>
<td>Cardiac Monitoring</td>
<td>IV Insertion</td>
<td>Multiple IV Infusions</td>
<td></td>
</tr>
<tr>
<td>Steri-Strip Application</td>
<td>Accompany to Lab or Rad</td>
<td></td>
<td>Newborn Care</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>5-20 points</td>
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<tr>
<td>99282</td>
<td>20-30</td>
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<tr>
<td>99283</td>
<td>30-40</td>
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<tr>
<td>99284</td>
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<td>99285</td>
<td>50 or more</td>
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<tr>
<td>99291</td>
<td>60 or more</td>
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### Table 2: The Matrix Approach

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<tr>
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<th>99282</th>
<th>99283</th>
<th>99284</th>
<th>99285</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescrip Refill</td>
<td>Abcess-Simple</td>
<td>Headache-Simple</td>
<td>Headache-Complex</td>
<td>Chest Pain-Cardiac</td>
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</tr>
<tr>
<td>Wound Check-Simple</td>
<td>Simple Rash</td>
<td>Cellulitis</td>
<td>Head Injury w/LOC</td>
<td>Cardiac Monitoring</td>
<td></td>
</tr>
<tr>
<td>Steri-Strip Wound</td>
<td>Insect Bite/Simple</td>
<td>Neb Treatment</td>
<td>Blood-Transfusion</td>
<td>Multiple IV</td>
<td></td>
</tr>
<tr>
<td>Triage Only</td>
<td>Cast Removal</td>
<td>Sprain Can’t Bear Weight</td>
<td>Pelvic Exam</td>
<td>Admit ICU/CCU</td>
<td></td>
</tr>
<tr>
<td>Epistaxis No Packing</td>
<td>Epistaxis w/Packing</td>
<td>Vaginal Bleeding</td>
<td>GI Bleed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Pain</td>
<td>Burn Treatment</td>
<td>Neb Treatment-Multiple</td>
<td>Severe Resp. Distress</td>
<td></td>
<td></td>
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<tr>
<td>Abdominal Pain Simple</td>
<td>Abdominal Pain-Complex</td>
<td>Epitaxis Complex/IV</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Distress</td>
<td>Lab Orders</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>EKG</td>
<td></td>
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<tr>
<td>Chest Pain Simple</td>
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</table>

**Matrix Approach**

A second approach to coding facility levels involves building a matrix that itemizes the hospital resources used and the procedures rendered in the ED by hospital personnel, and ties them into CPT® levels of service. This matrix mixes patient symptoms or diagnoses with ED hospitals services that typically are rendered for each level of service.

In our example, shown in **Table 2**, the coder would:

- Identify a patient condition (such as chest pain), hospital resources, and nurse of other ED personnel services or procedures that go with chest pain. For example, hospital resources used for chest pain are electrocardiogram (EKG), labs ordered, etc. These are listed under the matrix example of level 4, and result in coding of 99284 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity.

Treatments could appear under different matrix levels depending on the complexity of the patient problem and treatment, so a simple
The guidelines and possible interventions, and symptoms and examples that support the levels, are based on and developed by ED physician’s clinical experience. The result is a complete menu of services and procedures rendered in the ED.

nosebleed with no packing might be associated with 99282 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. But, a complex nosebleed requiring extensive packing and other services such as labs and/or IV—and the associated nurse hospital resources and time required—might result in a 99285.

Analysis

The matrix method, like the point system, requires that patient problems and complaints, as well as ED hospital treatment, are associated with the appropriate level of service. Also, the matrix must be complete in providing example patient conditions, services, and procedures that are associated with each level.

The simple matrix is closer to coding than the point system in that it recognizes what would be presenting problems, symptoms, and diagnoses, and the treatments that go with them. This allows the coder to weigh more factors than a rote point system, but greater coder decision-making is required to prevent under- and over-coding—particularly with patient complaints that could go with multiple levels, such as chest or abdominal pain. As with the point system, elements of the matrix must be associated with the appropriate level of service and must be complete in identifying ED resources used.

ACEP Facility Level Guidelines

A methodology that combines the best of the matrix approaches and point systems is the ACEP’s ED Facility Level Coding Guidelines (www.acep.org/Content.aspx?id=30428). The guidelines associate interventions and possible interventions with each level of service. Unlike with point systems, additional interventions that are associated with lower levels are not added to arrive at a level. The ACEP method builds logically from level to level with examples of additions that support the levels, are based on and developed by ED physician’s clinical experience. The result is a complete menu of services and procedures rendered in the ED. When used correctly, the ACEP guidelines can be a very good choice.

ACEP also provides nature of presenting problems in their instructions. Although these are not an essential element of leveling instructions, they do focus the coder on real-world situations encountered in the ED, with more complex presenting problems usually associated with higher levels. In incorporating presenting problems, the ACEP approach feels more like actual coding than other approaches.

Commercial Level of Service Systems

Several marketed systems produce ED levels based on elements factored by proprietary software (for example, by factoring many possible presenting problems with intervention examples to calculate levels). Two such ED facility coding systems are the Picis LYNX E/Point® system and Horizon Intelligent Coding™ by McKesson.

Analysis

These systems can be effective. If you’re considering such a system, compare several products in terms of price, user friendliness, and features. Consider also speaking with current and former clients.

People Make the Difference

Regardless of methodology, the personnel performing ED leveling are critical. Our experience shows that personnel doing this work should be experienced ED coders; however, in many hospitals, nurses, medical records coders, or even clerks do the leveling. This can only work with complete guidelines, proper training, and ongoing review. If a hospital cannot make the time and investment necessary to properly perform ED facility coding, outsourcing (very common on the physician side of the ED) is an option. Only consider reputable companies, and be sure to check references. There also are organizations that do outsourced ED facility coding, such as Medical Management Professionals, Inc. (MMP), Medical Recovery Specialists, Inc. (MRSI), and Medical Management Resources, Inc.
Kansas City Gets Involved in a Big Way  Submitted by Cathy Jennings, CPC, CHONC

It’s amazing what can come from an AAPC local chapter meeting. There is always great education and networking; however, comments made at one local chapter meeting in Kansas City led to the decision to become more involved in their community. It started with a presentation by a doctor talking about bone marrow transplants. After realizing how desperate the need was, several AAPC of KC chapter members asked what they needed to do to get on the national bone marrow donor registry.

Members Wanted to Do More
AAPC of KC chapter members started talking, which led to a presentation to the local chapter board about getting a bone marrow drive started. As it turned out, the board and many members (along with their family and friends) were hugely supportive of this first community project. Not only did the local chapter host a very successful bone marrow registry drive, “Be the Match” (www.marrow.org), they also raised money by collecting donations and holding a silent auction. Realizing that coders could make a real difference in their community, this project became the first of many for the chapter.

Next Project, Camp Hope
AAPC of KC is now in the process of working on their second annual community project. This time, the organization in need is Camp Hope, which is run by the American Cancer Society as a free summer camp for children with cancer. It not only gives them a chance to see that they are not alone in their fight against cancer, but gives them a chance to be a kid again with a summer camp experience. The American Cancer Society is helping the chapter set up a website for information and donations at http://community.acsevents.org/aapc.

AAPC of KC hopes to inspire and challenge other local chapters to become more involved. You’ll never know how rewarding it can be until you start. With so many possibilities and so many organizations in need, the most difficult part is deciding who to help next. Please help out in your community. You can organize your own big event to raise funds and awareness, or you can do something simple like start a team to join in a walk that someone else has already organized in your area. The options for helping others are endless.

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Evaluating and management (E/M) services represent the most significant financial and compliance risks to any practice for two reasons ...
Dear AAPC,

I recently attended my first workshop (Advanced Surgical Chart Auditing) and it was awesome! The interaction between the instructor and the students made the training exceptional. I learned so many new techniques from the information and tools in the presentation, as well as from the other coders in attendance. The hands-on exercises were perfect to solidify my understanding of the material we covered. I have already taken what we studied at this workshop and applied it successfully in my daily work as an auditor. I can’t wait to attend May’s workshop, Advanced E/M Chart Auditing!

Sandy D.
Idaho Falls, ID

Don’t miss AAPC’s May workshop!

Advanced E/M Chart Auditing

Select dates between May 18 - May 28

Find a workshop location near you and register today!

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Maryann Palmetter: Coding, Compliance, and Cows

2010 Member of the Year brings endless energy, devotion, expertise, and fun to the coding profession.

Although being speechless is a rarity for Maryann C. Palmetter, CPC, CENTC, she couldn’t find the words to describe how she felt when she first learned she was named AAPC’s 2010 Member of the Year. When Palmetter collected her thoughts, she said, “I am extremely honored and humbled because I know how many coders belong to AAPC and how hard each and every one of them works at their profession.”

Over 27 Years in the Field

Palmetter started in our industry in 1982 with Blue Cross and Blue Shield of Florida, Inc. Her first job was as a Medicare Part B claims examiner and she worked her way up to supervisor of an auditing department. While Palmetter worked for the Blues, she learned a lot about Medicare policy, and she provided education and training to new employees on claims processing.

In 1992, Palmetter began working for the University of Florida Jacksonville Physicians, Inc. as a Medicare follow-up and collections coordinator. She had to take a pay cut but was eager to learn the other side of the business. She was promoted to supervisor of Medicare and Medicaid follow-up and collections, and then became a provider education specialist where she was responsible for supervising coders who extracted physician charges from inpatient medical record charts. She also was responsible for educating physicians on evaluation and management (E/M) documentation guidelines and Medicare teaching physician documentation rules.

In 1998, a manager position became available in the office of compliance at University of Florida Jacksonville Healthcare, Inc., where she is now the director of physician billing compliance.

Eager to Lend a Hand

Palmetter played a key role in the success of AAPC National Conference when the 2010 Nashville, Tenn. flood prompted a last minute change of venue to Jacksonville, Fla. She personally donated money and encouraged her local chapter to raise funds for the “Project AAPC” effort, which aided flood victims in Nashville. She also solicited local vendor donations for attendees. With help from others, Palmetter convinced her employer to sponsor 50 attendees for the AAPC National Conference.

Local Chapter Sings Praise

Palmetter has done so much for her chapter and other local chapters that it’s hard to fit all her accomplishments in one article; however, let’s try.

As relayed by Jacksonville Beach’s chapter President Jeannette Bacon White, CPC, and Melissa Brown, RHIA, CPC, CPC-I, CFPC, of the AAPC Chapter Association (AAPCCA) Board of Directors, here are some of Palmetter’s 2010 local chapter accomplishments:

- When the National AAPC Conference was diverted to Jacksonville, Fla., White said Palmetter “single handedly organized the Jacksonville Chapter’s volunteers into fully trained, well-organized, and care-free people, working together as one cohesive group.”
She played a lead role in coordinating with other Jacksonville local chapters and other Florida chapters to create and display two booths at the “Get to Know Your Local Chapter” event at the AAPC National Conference, both of which took ribbons (third and first).

White said, “She brings to the arena encouragement, knowledge, and just plain ‘ole’ fun at all gatherings.” She takes pride in everything she does, “no matter how large or small the task. Through her efforts, the attendees at the convention received the best that Jacksonville had to offer.”

She has endless energy when it comes to helping people continue their medical billing and coding education.

She proctors CPC exams.

Palmeter provides solicited and unsolicited feedback to AAPCCA representatives and national office representatives on issues facing AAPC members.

She promotes AAPC and encourages people to use the website for more information. She responds to postings on AAPC website’s coding forums and corresponds with AAPC members via social media websites.

She is regarded as having encyclopedic knowledge of Medicare and Medicaid regulations.

She routinely answers coding and billing questions (citing backup material) submitted by members of the local chapter, audience members from lectures, and the coding community in general.

Her opinions are well-supported, which prompts publications to seek her opinion, and she’s been quoted in Part B News.

As a member of the ENT specialty exam steering committee, Palmeter worked closely with AAPC to develop the CENTC specialty credential exam.

She developed and instituted distribution of “New Member Welcome Cards” and “New CPC Congratulations Cards” to acknowledge and recognize new local chapter members and chapter members with new certifications.

She regularly submits ICD-10 readiness articles for the company newsletter, reaching over 200 CPCs in the process.

Palmeter also has presented numerous lectures and learning opportunities for local chapter meetings and seminars.

**Work Sings Praise**

Palmeter’s devotion to coding excellence and our profession does not stop at her local chapter. It continues in the workplace. Seth Canterbury, CPC, ACS-EM, education specialist, University of Florida Jacksonville Physicians, Inc., Clinical Data Quality Education Department, said:

“Maryann Palmeter has been a devoted member of the medical billing, coding, and auditing community for 27 years. Over the years, her tireless dedication has been exhibited in many endeavors she has engaged in to further the profession and educate its members. In her current position as director of physician billing compliance with the University of Florida Jacksonville Healthcare, Inc., she has built a solid reputation as an authority on and advocate of compliant billing and coding practices. She regularly communicates with all medical departments regarding billing compliance issues and serves as an authority on issues relating to coding and/or billing compliance. She also co-chairs the Communication and Education Committee of the organization’s ICD-10-CM Implementation Team. Not content with merely the preservation of the status quo, she has made it her goal to ensure that the ICD-10 transition will result in improved documentation quality and code capture.”

**Who Puts the Wind in Her Sails?**

With so many goals accomplished in 2010, you may ask “How can someone do so much?” Palmeter said her supportive husband, Steve Palmeter, whom she met at the Blues, helps her achieve her goals.

Palmeter said, “He has listened to many presentations many times over, he has held down the fort when I have proctored exams on Saturdays.” Palmeter’s husband knows when her head is ready to erupt from government regulatory overload and “he conveys the message to the children to stand clear” without frightening them, and he ‘feeds and waters’ the kids” on those nights when she attends local chapter meetings or has to work late. She said, “Of course, our kids like this because they get to eat their favorite dish (my not-so-favorite), Tater Tot® casserole.”

Palmeter’s Advice to Colleagues

Industry tip: “Sometimes one must take a pay cut to learn the other side of the business.”

*cont’d on page 38*
AAPC Welcomes 2011-2013 NAB Officers and Regional Board

AAPC’s National Advisory Board (NAB) is a diverse group of professionals with a wide range of experience in the health industry. Representing members in eight regions of the United States, board members pull together their individual strengths to be a voice for our membership. We’re pleased to announce our new NAB for 2011-2013.

President
Cynthia L. Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P

Revenue Cycle Systems Manager, St. Vincent Health

Cynthia Stewart has been member of AAPC since 1998 and a longtime advocate. She was the 2006 president of the Central Indiana Chapter prior to serving as an AAPC NAB member in 2007. She has more than 25 years of experience in the medical profession. In the past 15 years, she has applied her knowledge and skills in several capacities, including billing supervisor, practice manager, senior coding specialist, coding and reimbursement consultant, and director of medical billing, coding specialist, and health care management programs. Stewart also is an AAPC workshop presenter and provides instruction as a reviewer, contributing author, and research assistant for various coding and billing text.

President-elect
David B. Dunn, MD, FACS, CPC-H, CIRCC, CCC, CCS, RCC

Vice President, ZHealth

Dr. David Dunn, vice president of ZHealth, oversees physician coding and manages ZHealth operations. In 2002, he joined his longtime colleague, Dr. Z, at ZHealth and is a regular instructor for ZHealth educational programs and a contributor to Dr. Z’s Medical Coding Series reference books. A graduate of Texas A&M University, he completed his Doctor of Medicine degree at the University of Texas in San Antonio, his surgical residency at Scott & White Hospital in Temple, Texas, and his vascular surgery fellowship at Baylor College of Medicine in Houston. A diplomat of the American Board of Surgery, Dunn is also certified in vascular surgery. He is a fellow of the American College of Surgeons and a member of the Southern Association for Vascular Surgery.

Member Relations
Melody S. Irvine, CPC, CPMA, CEMC, CPC-I, CCS-P, CMRS

CEO and Founder, Career Coders, LLC

Melody Irvine has over 30 years of experience in the medical profession. She specializes in physician auditing, education, curriculum development, and consulting services. She is the CEO and founder of Career Coders online medical billing and coding school. Irvine is an approved Professional Medical Coding Curriculum (PMCC) instructor with AAPC. She is also employed as an instructor for National Alliance for Medical Auditing Specialists (NAMAS)/DoctorsManagement, LLC, and is co-author of AAPC’s Certified Professional Medical Auditor (CPMA) study guide and curriculum. Her extensive background includes director of coding/auditing, compliance/Health Insurance Portability and Accountability Act (HIPAA), and urgent care for a 48 multi-specialty physician practice. She spends most of her time speaking nationally. Irvine is founder and past president of AAPC’s Loveland, Colo. Chapter. She was appointed to AAPC’s NAB for 2009-2011. Her true passion is teaching and she is motivated by career challenges.

Secretary
Kerin Draak, MS, WHNP-BC, CPC, CPC-I, CEMC, COBGC

Coding Educator, Prevea Health

Kerin Draak has been involved in the health care field for more than 18 years. She earned her undergraduate degree from University of Wisconsin (UW) Oshkosh in 1991, and then worked as a labor and delivery nurse in the hospital. After earning her graduate degree from UW Madison in 1995, she began a nurse practitioner career. She has over 11 years of clinical experience in women’s health. Her coding career started in 2004. Since then, she has been the coding educator for a 220+ multi-specialty clinic, has been involved in the development of the internal chart audit program, and has developed educational tools, guides, and policies for the clinic. Draak has spoken at both regional and national conferences for AAPC.
Region 1


*Director 5010/ICD-10 Communication, Adoption, and Training, UnitedHealth Group*

Angela “Annie” Boynton has served in the health information management field for over 10 years in provider, payer, and educational capacities. She is director of 5010/ICD-10 communication/adoption and training at UnitedHealth Group. She also develops curriculum and teaches medical coding at Massachusetts Bay Community College, and teaches health information technology at Fisher College. Boynton represents UnitedHealth Group on the joint WEDI-AHIP ICD-10 Consortium and was a developing member of AAPC’s ICD-10 implementation training curriculum. She holds several certifications and degrees in health information technology and health care management, and is pursuing graduate work in health law and health care informatics.

Terry Streit, BSN, RN, LNCC, CPC - Clinton, N.Y.

*Medical Investigator, Special Investigations Units, Excellus Health Plan, Inc.*

Terry Streit is a medical investigator with Excellus Blue Cross Blue Shield (BCBS), in Utica, N.Y. Her responsibilities include investigation and auditing of medical fraud, waste, and abuse. She is privileged to work with Frank Dubeck, MD, FACP, CPE, who is a member of the American Medical Association’s (AMA’s) CPT® Editorial Panel. Prior to becoming a medical investigator, Streit served in medical records review and utilization management. She has spoken at the National Healthcare Anti-fraud and Abuse (NHCAA) Symposium. Streit also serves as president of her AAPC local chapter.

Region 2

Nancy Clark, CPC, CPC-I – Elberon, N.J.

*Director, Healthcare Business Resource Center*

Nancy Clark is director of the Healthcare Business Resource Center, where she coordinates and instructs PMCC, and manages coding and reimbursement for several specialty providers. Clark also is a senior health care consultant for a premier accounting and business advisory firm in the Northeast. She serves as a coding and documentation specialist and performs audits for both physician and hospital clients. She is a member of the Highmark Medicare Provider Outreach and Education Advisory Group. Clark is a proud co-founder of the successful New Jersey Coders’ Day Medical Coding and Billing Conference. She enjoys volunteering for the Monmouth, N.J. chapter and looks forward to contributing to AAPC and working with its members.


*Director of Operations, Department of Medical Oncology and Jefferson Infusion Centers, Thomas Jefferson University*

Maria Rita (Rita) Genovese has been a member of AAPC since 2003. She is president of the Greater Philadelphia chapter. She also served as chapter president in 2008 and as new member development officer in 2009. Genovese has over 20 years experience in billing and practice management, most recently in the areas of family medicine and medical oncology. As director of operations, she manages a practice of 37 physicians, two outpatient infusion centers, and a support staff of 190. Genovese actively educates physicians and staff in medical coding and compliance regulations.

Region 3


*President, Practice Integrity, LLC*

Jaci Johnson has been working in the field of medical coding and auditing for 22 years and has been a CPC® since 1994. She teaches PMCC and manages a national client list, providing compliance monitoring for provider documentation. Johnson was recognized as Coder of the Year for the commonwealth of Virginia in 2006. She is the past president of her local AAPC chapter. Johnson received her bachelor of science in finance from Virginia Tech.

Marianne Durling, BS, CPC – Oxford, N.C.

*Instructor, Health Care Management Technology/Medical Coding*

Marianne Durling has been involved in health care or health insurance for 30 years. She teaches health care management and medical coding programs at Piedmont Community College. She developed a successful medical coding program that has a 90 percent pass rate on the CPC® exam. Durling has owned a successful medical bill auditing company for 13 years. She provides expert witness and case review services to attorneys nationwide, as well as textbook review and editing for multiple publishers. She has a bachelor’s degree in health care management and is completing her master’s degree in health care administration. She is president-elect of the Roxboro, N.C. chapter.
Region 4


Billing Director, Healthcare Management Services, LLC

Karen Collins has over 13 years of medical coding experience. She began working in the medical field in 1999 as a billing and collections specialist. She has experience as billing manager of pediatrics, family practice, and internal medicine and most recently billing director for a Healthcare Management Services, LLC. Her expertise is in denial management, compliance, and reimbursement. Collins is a member of AAPC, PAHCS, AHIMA, HCCA, and HFMA. She is certifying in physician compliance and finishing her bachelor of science in business & information technology at Macon State College, Ga. Collins has served on the PAHCS Specialty Board for Pain Management, as education officer for AAPC’s Macon chapter, as co-chair for Certified Financial Counselor for HFMA, and is on the Editorial Board for BC Advantage magazine.

Maryann C. Palmeter, CPC, CENTC – Orange Park, Fla.

Director of Physician Billing Compliance, University of Florida Jacksonville Healthcare, Inc.

Maryann C. Palmeter has over 27 years of extensive health care experience in both government contracting and physician billing. She is the director of physician billing compliance at the University of Florida Jacksonville Healthcare, Inc. and provides professional direction and oversight to the billing compliance program at the University of Florida College of Medicine Jacksonville. She is the education officer and a two-time past president of the Jacksonville, Fla. chapter. Palmeter is AAPC’s 2010 Member of the Year.

Region 5

Stephen C. Spain, MD, FAAFP, CPC – Tyler, Texas

Founder, Doc-U-Chart

Dr. Stephen Spain has been engaged in the full-time practice of family medicine for over 25 years. In 1998, he founded Doc-U-Chart, a consulting firm specializing in charting documentation and medical auditing. He is president-elect of AAPC’s Tyler, Texas, Rose chapter and teaches coding for Tyler Junior College. Spain frequently speaks and writes on proper coding, coding ethics, and regulatory compliance.

Lillie K. Washington, BSN, RN, MSM, CPC, CMSCS – San Antonio, Texas

Quality and Patient Safety Coordinator, CHRISTUS Santa Rosa Children’s Hospital

Lillie Washington has 26 years of health care experience in the areas of med-surg, urology, pediatrics, rehabilitation, emergency services, quality and utilization management, medical policy development, data analysis, local provider education and training, auditing, appeals, compliance, population, and care management. She spent 16 combined years with a Medicare intermediary, Medicare carrier, Medicaid fiscal agent, and BCBS. She has served as an expert witness for U.S. Department of Justice (DOJ). She has presented at local, state, and national conferences. Washington holds a bachelor of science in nursing from the University of Southern Mississippi and a master’s of science in management from Belhaven University.

Region 6

Amy S. McCreight, CPC, CPMA, CEMC – Delaware, Ohio

Coder Trainer, HealthProviders at Mount Carmel

Amy McCreight has 18 years of experience in the health care administrative and coding arena, including seven years as a CPC®. She has been a medical billing and coding instructor for the past 10 years. Most recently, she instructs at the Delaware Area Career Center and is passionate in training new coders. She is a coder trainer for HealthProviders at Mount Carmel, where she performs chart audits and provides education for billers, coders, and providers of numerous specialties. Since 2003, she has been an active member of AAPC’s Columbus chapter and founded the Delaware chapter in 2006. McCreight has served as treasurer of the Columbus Chapter and president, president-elect, and education officer for the Delaware chapter.

Debbie Senarighi, CPC, CPC-H, CPC-P, CPMA – Duluth, Minn.

Physician Coder, Essentia Health

Debbie Senarighi has more than 28 years of experience in the health care industry, working as a physician coder, hospital coder, denial and appeals specialist, and she has also worked in the claims area of the insurance industry. She has an associate degree in supervisory management and human resources. Senarighi has served as the president and education officer of the Duluth, Minn. chapter. She is employed at Essentia Health, a large multi-specialty clinic as a physician coder. She strives to “always do the right thing” and to “keep learning for a lifetime.”
Region 7

**Doris Davis, CPC – Helena, Mont.**

*Adjunct Professor, University of Montana*

Doris Davis is an adjunct professor at the University of Montana, a forensic auditor, and a medical coding/investigative consultant specializing in health care fraud and abuse audits and coding education. As a practice administrator, consultant, forensic auditor, seminar leader (McVey Seminars), guest lecturer at medical schools and universities, patient advocate and passionate educator, she has introduced the AAPC to thousands of coders nationwide. She is a former PMCC instructor and founder and president of AAPC local chapters in New Jersey and Pennsylvania. In 2009, Davis moved to Helena, Mont., where she was instrumental in founding AAPC’s Helena local chapter. She’s held the offices of treasurer and education officer and is the 2011 president-elect.

**Kate Tierney, CPC, CPC-P, CEMC, COGC, CGSC, CEDC, CEHRS, CCS-P, CHI, CPhT, CBCS, CMAA**

*Coding Hub Supervisor, Centura Health Systems – Littleton, Colo.*

Kate Tierney has over 25 years of experience in the health care industry at many levels. She served as the education director for AAPC’s Englewood, Colo. chapter during 2008 and 2009, and taught coding and billing classes for five years. In addition to supervising the Coding Hub for Centura Health Systems in Colorado, she is the coding consultant for MES Solutions, an independent medical peer review company. She also helps develop coder testing materials for many Denver medical personnel services. When she is not coding, Tierney is involved with her church and on the board of the Colorado United Irish Societies.

Region 8

**Cindy Cox, CPC, CPMA - La Habra, Calif.**

*Behavioral Health and HIV Medical Coder, County of Orange*

Cindy Cox has been a CPC since 2006 and a CPMA since 2009. Her experience includes 20 years in the medical field. As a medical coder/auditor for Orange County, Calif., she specializes in the departments of behavioral health, HIV, and integrity agreement (IA)/Office of Inspector General (OIG) compliance audits. She has coordinated local coding development seminars for her local chapter, trained staff within Orange County and San Bernardino County compliance. Cox served as president-elect in 2009 and president in 2010 for AAPC’s Orange, Calif. chapter.

**Toni Slocum, CPC, CPC-P – Portland, Ore.**

*Health Care Fraud Investigator III, Regence BCBS*

Toni Slocum holds dual coding credentials and has been involved in the health care industry for the last 17 years. She was the program director for the Medical Insurance Billing and Coding program at a Portland area college, and a coding teacher at other venues. Slocum is past president of the Columbia River Coders chapter, and was instrumental in starting a successful, annual, two-day coding conference. She also served as chair of the local advisory board and as lead conference coordinator.

AAPC Liaison

**Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC**

*Vice President of ICD-10 Education and Training*

Rhonda Buckholtz is the vice president of business development and member relations for AAPC. A seasoned coder and coding educator, she previously served AAPC as director of local chapter relations and as a member of NAB. She is a certified coder and PMCC instructor, and speaks frequently at coding conferences. She is the owner of Coding and Reimbursement Experts, a Pennsylvania coding consulting service, and teaches coding at the Venango campus of Clarion University. Prior to her employment with AAPC, Buckholtz was administrator for Wolf Creek Medical Associates, managing a five-location, multi-specialty practice and was business manager at an otolaryngology practice.

Chairman

**Reed Pew**

*Chairman, AAPC*

Reed Pew is chairman of AAPC. He is excited about the changes in AAPC and the NAB, and looks forward to getting to know the members.

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Aneta Solana, CPC, Plainfield IL
Bridgette Martin, CPC, Evansville IN

Here are a few of her other favorite things:

- Music: Tuna Nguyen, CPC-A, Santa Ana CA
- Animal: Diana Fontana, CPC-A, Afton CA
- Recreation: Jeff Games, CPC-A, Arlington TX

As we can see, Suzanne Massey has a variety of interests and passions, which she also brings to her work as a CPC. Her dedication to her profession is evident in her professional accomplishments and her commitment to continuing education, as reflected in her participation in the AAPC Coding Edge and her recognition as a newly credentialed member.

Get to Know Maryann Palmer

Maryann Palmer’s spare time is spent with her husband, Steve Palmer, and two sons, ages 9 and 15. They also have an adult son and an 8-year-old grandson who live in Maryland, who she says they don’t get to see often enough. Here are a few of her other favorite things:

Music: Palmar is a Paparazzi. “If you have to ask what that is, then you wouldn’t understand,” she said lightheartedly.

Books: Loves to read, particularly history.

Games: Soduko, FarmVille and YoVille.

Animal: Cows. She has an extensive cow collection. She loves cows so much that her user name is “Jaxcowlover,” and she is happy to live in a city that the British once called “Cowford.”

Addictions: Facebook.

Recreation: Bike riding, swimming, and going to yard sales.

Future Aspirations: A degree in health care administration.

The second person Palmer wishes to recognize is her mentor, Legal Advisory Board and former NAB member, Robert A. Pelaia, Esq., CPC, CPC, Pelaia works for the University of Florida as the senior university counsel for health affairs in Jacksonville. He was also the former director of compliance and Palmer’s former boss. Palmer said about Pelaia, “He encourages me to continue my work with the AAPC; he urges me to continue my pursuit of higher education; he said about Pelaia, “He encourages me to continue my work with the university counsel for health affairs in Jacksonville. He was also the former director of compliance and Palmer’s former boss. Palmer said about Pelaia, “He encourages me to continue my work with the AAPC; he urges me to continue my pursuit of higher education; he is a great devil’s advocate and barometer reader; he continues to chas-tise me about my messy office; and he is a good friend.”

Lastly, Palmer said, “Although not an individual, I would be remiss if I did not recognize the significant role that the University of Florida College of Medicine – Jacksonville has played in my coding career.” Specifically, she recognizes the physicians, non-physician practitioners, and residents who work on the Jacksonville campus. “They perform miracles every day and in every specialty from anesthesiology to vascular surgery,” she said. “They are always on the cutting edge and that alone keeps me on my toes.”

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Maryann Palmer: Cont’d from page 29

Palmer’s story is one of dedication and perseverance, as she continues to advance her knowledge and skills in the field of medical coding. Her passion for learning and her commitment to excellence are evident in her dedication to staying updated with the latest developments in the field. Her contributions to the AAPC Coding Edge and her recognition as a newly credentialed member are a testament to her dedication and hard work. Palmer’s story serves as an inspiration for others in the medical coding field, showing that with determination and a thirst for knowledge, one can achieve great things.
Audit Team Finds Paradise

Nine women fulfill their dream to live and work overseas.

Technology has been instrumental in the evolution of the medical coding industry. Telecommuting, in particular, opens doors to coders who desire to spread their wings. Where the wind takes these coders makes for many interesting stories. Consider, for example, the true story of nine coding auditors: all are U.S. citizens; all live in one of five different European countries; and all work together, albeit remotely, as auditors for the U.S. Air Force (AF). With the use of computers, coding knowledge, and certifications, the world has become their office. Each has her own story about how she started auditing in her country of choice.

**Ida Landry, CPC**

Back in 2006, I took a vacation to Italy and loved it. On my flight back to the United States I thought it would be nice to live in a European city or town to get a sense of the culture, instead of being a tourist. Not long after, I saw an advertisement in the AAPC job database for a traveling auditor with the AF in Germany. I knew my seven years of coding experience qualified me for the position, and I had to go for it. The job opportunity enabled me to learn the German culture firsthand, and I have satisfied my desire for travel. I will soon move back to Portland, Ore., but my time in Germany was everything I wanted for my career and personally.

**Cecily Pewitt, CPC, CPC-H**

Medical coding and auditing is my third and favorite career because it has allowed me to live, work, and travel in Europe for almost five years. In 2005, I was an empty nester when a friend of mine told me about the Medical Coding Auditing program for the U.S. Air Force in Europe (USAPE). The next thing I knew, I was on a plane to the United Kingdom. I was able to live, work, and travel around England, Wales, and Scotland for the next two years. In 2007, I accepted a position in Germany. With that country crossed off my “I’ve been there” list, I went on to work in Italy as a medical coding auditor. I have been at Aviano Air Base in Italy for about nine months and I am loving it as much as I loved England and Germany. Where to next?
Deborah David, CPC, CPMA

While finishing up a college degree, I began searching for better job opportunities when I stumbled across an ad on the AAPC job site for a position in Europe. I was transported from a small town in Georgia to a small town in Germany. By chance, I was fortunate enough to be at the same AF base where my son-in-law was stationed; so I've spent my first year and a half overseas with my daughter and two grandchildren. I've taken advantage of my location and have traveled to 13 countries throughout Europe. There is a saying among the Airmen here: When asked, “How are you?” they often answer, “Living the dream.” That’s how I feel!

Cindy Lowe, RHIT, CPC, CPC-I, CCS-P

My career path in health care management had taken me many places in the United States serving in acute care hospitals, physician practices, community health, and the AF military health system. In the spring of 2008, I was at a point in my life where I had the liberty to change my direction and pursue my interests. I made a decision not to cruise aimlessly down life’s journey, missing the adventure. When I saw a position open to serve our troops in Europe, my love of travel and history was the catalyst for accepting a leadership role with the headquarters USAFE Command Surgeons Office. After many years away, I have returned to my roots, serving the military community. It is an honor to work with a team of dedicated professionals.

Tiffany I. Windmon, CCS-P

I had been traveling as a coding consultant when I discovered that living in hotels, driving a different car every other week, meeting people from all around the United States, and eating in a variety of restaurants was an acquired taste—one that I enjoyed. Being a coding consultant means downtime is almost as consistent as the time spent working. During one of my down periods, I was looking for exciting travel opportunities when a fellow coding consultant e-mailed me an opportunity to live my exciting life overseas. I was offered an auditing position in the Azores, Terceira Island Portugal, and have not looked back since. Since then, I have relocated to Germany. Living overseas has been a worthwhile experience, which I intend to make more permanent. Where will I end up next? I have my eyes set on Japan.
Ngina Lynch, CPC, CPC-I
By the end of 2007, I had been teaching coding and medical administration classes for about three years and was ready for a new challenge. My dream was to live and work abroad—I never imagined coding would take me as far as Incirlik, Turkey. It has been a truly amazing and challenging ride ever since. I have experienced a life so completely different from my own back in Baltimore: Giving birth to a wonderful baby girl named Beatrix; indulging my passion for ancient history and different cultures; meeting so many great people; eating well in Germany, Cyprus, Morocco, and my home city in Turkey. I don’t know where the next opportunity will take my family, but we can’t wait for our next adventure (In-sallah, I hope).

Linda Barbooa, CPC
Ola! I am the medical coding auditor at Lajes Field in the Azores, Portugal. I am originally from Albuquerque, N.M., and was the Albuquerque AAPC chapter president the year before I left. I have a lot of experience in coding/auditing and spent most of my career in cardiology. Now, I am on a small, 23 square mile island in the middle of the Atlantic. I love my job! I work with a team of very experienced and knowledgeable ladies. There are nine of us scattered throughout USAFE. I have the greatest supervisor, Cynthia Lowe, of my entire working career and I have the total support of my chief of medical staff (SGH). There is nothing better than working on a beautiful island with great support from co-workers.

“There is nothing better than working on a beautiful island with great support from co-workers.”

Sabrina Brundage, CPC
My overseas experience started many years ago as the dependant spouse of an AF enlistee. We were stationed in Karasmsal, Turkey. It was wonderful and we traveled as much as possible on a sergeants’ pay. Years later, we traveled to England and Scotland and I fell in love with both places. When I saw the opportunity to work and live in the area, I jumped at the chance. My many years of coding for civilians and the military gave me the foothold I needed to get the job of a lifetime. It’s a dream come true to work and travel in the areas I have always studied (history is my passion) and longed to visit. I enjoy getting to know the locals and trying new things, and I cherish the relationships all of us transient coders share.
Append 22 to Unusually Difficult Procedures

When properly applied, modifier 22 Increased procedural services allows a physician to receive greater reimbursement for an especially difficult or time-consuming procedure. But getting modifier 22 claims paid requires more than just extra work in the operating room—it also means a greater effort when documenting and submitting the claim.

Master the Basics
As explained in CPT® Appendix A, modifier 22 indicates that the work performed during a particular procedure was “substantially greater than typically required...” Neither CPT® nor the Centers for Medicare & Medicaid Services (CMS) guidelines precisely define a “substantially greater” effort. As a practical matter, you should follow specific payer requirements (e.g., some payers require that the work be “at least 25 percent greater than usual”). Regardless of payer, you should append modifier 22 infrequently, for only the most unusually difficult procedures.

Modifier 22 is for physician reporting only (facilities may not report modifier 22), and should not be appended to evaluation and management (E/M) codes, according to CPT® guidelines. Most commonly, modifier 22 will accompany surgical claims—although modifier 22 also might apply to anesthesia services, pathology and lab services, radiology services, and medicine services. Circumstances that may call for modifier 22 include the following:

- Increased service intensity or procedural time
- Increased technical difficulty, or physical and/or mental effort
- An especially severe patient condition

Specific instances when you might apply modifier 22 could include extensive scarring from a previous injury or surgery, excessive patient blood loss for the particular procedure, trauma extensive enough to complicate the particular procedure (but not billed as additional procedure codes), anatomical variants, or even morbid obesity in a patient that makes a procedure much more difficult than is typical.

Do not apply modifier 22 if another CPT® code (including an unlisted procedure code) more accurately describes the performed procedure. To give an example, if the surgeon performs laparoscopic hiatal hernia repair using mesh, do not report 43332 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis with modifier 22 appended to describe the mesh placement. Instead, report 43333 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis, which appropriately describes the procedure (including mesh placement) without the need of a modifier. In other words, modifier application shouldn’t be a factor in code selection, but only to alert the payer that there is something “unusual” about the claim.

State Your Case
Knowing when and how to append modifier 22 is less than half the battle. The real work, from a claims submission standpoint, is justifying to the payer that the modifier is appropriate in a particular circumstance, so the additional payment is warranted. Put
Medical practice is inherently “difficult,” but difficulty alone doesn’t justify appending modifier 22.

Not Every Difficult Procedure Merits Modifier 22

Medical practice is inherently “difficult,” but difficulty alone doesn’t justify appending modifier 22. The procedure must be unusually difficult in relation to other procedures of the same type. CPT® codes (or, more precisely, the values assigned to those codes) assume an “average” service. Patient A’s cholecystectomy on Tuesday may go more smoothly than Patient B’s cholecystectomy on Thursday. Rather than price each cholecystectomy individually, the payer reimburses a standard amount with the assumption that the “easier” and “more difficult” cases will average over time.

Only rare, outlying cases—those that are far beyond the average difficulty—call for modifier 22. As the American Medical Association’s (AMA’s) 2008 CPT® Changes: An Insider’s View explains, “This modifier should be used only when additional work factors requiring the physician’s technical skill involve significantly increased physician work, time, and complexity than when the procedure is normally performed.”

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For 2011, the American Medical Association (AMA) made some notable changes in the Nervous System section of the CPT® code book. CPT® 2011 adds four new codes describing procedures related to peripheral nerve neurostimulation, deletes one related code, revises another, and updates parenthetical information to assist code selection and application.

**Added Code Reports Stimulation for Urge Incontinence**

New this year is CPT® code 64566 Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming.

Posterior tibial neurostimulation (PTNS) is a minimally-invasive procedure that stimulates the sacral nerve plexus by way of the tibial nerve, to treat urge incontinence (the sacral nerves play an important role in regulating bladder control). A needle electrode is placed through the skin adjacent to the tibial nerve near the ankle to deliver stimulation intermittently for approximately 30 minutes. Treatment may include several sessions; 64566 describes a single session, and includes programming of the device.

For additional explanation and a video describing PTNS, go to: www.uroplasty.com/index.cfm/go/Patients.UrgentPC.

A new parenthetical CPT® instruction specifies that you should not report 64566 with 64555 Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve) or 95970-95972 (electronic analysis of implanted neurostimulator pulse generator system).

**Cranial Stimulation Gains Several Codes**

Three codes are added to describe procedures related to cranial nerve stimulation. The first of these, 64568 Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator, reports incision for implantation of the electrode array and pulse generator.

In previous years, this procedure was reported using component codes that separately described, for instance, the incision (64573) and insertion (61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array) of the pulse generator. For 2011, all services are combined in the single code 64568, and the incision for implantation code 65473 is deleted.

CPT® instructs you not to report 64568 with 61885, 61886 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays, or new code 64570 Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator (discussed below).

Surgeons sometimes must revise and/or replace the electrode array for a cranial neurostimulator. The pulse generator must be revised at the same time for connection to the new electrode array. Because this requires greater effort than placing the electrodes/generator for the first time, a dedicated code (64569 Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator) has been added to report the procedure.

Do not report 64569 with 64570 or 61888 Revision or removal of cranial neurostimulator pulse generator or receiver. For revision or replacement of pulse generator (rather than electrode array) only, report 61885.

If the electrode and pulse generator both are removed without replacement, report new code 64570. Do not report 64570 in addition to 61888 for revision/removal of the pulse generator.
Surgeons sometimes must revise and/or replace the electrode array for a cranial neurostimulator. The pulse generator must be revised at the same time for connection to the new electrode array.

or receiver; the revision/removal is bundled into 64750.
To better understand how to code implantation, revision/replace-
ment, and removal of the various components of the cranial neuro-
stimulation system, refer to the easy coding chart shown in Table A.

Table A. Cranial Nerve Neurostimulation Easy Coding Chart

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For example, a surgeon implants a vagus nerve (cranial nerve X) neurostimulator electrode array and pulse generator. Report this using 64568, which describes the incision and placement of both components. Sometime later, the surgeon must replace the electrode array. Report this using 64569 (This also includes the necessary revision of the generator to accommodate the new electrode array connections.). At a still later date, the entire system (pulse generator and array) is removed. Removal of all components is reported using 64570.

64575 Becomes a “Parent”

Code 64575 Incision for implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve) has been revised so that it is no longer a “child” of (now deleted) code 64573. Instead, 64575 becomes a parent code to 64577 Incision for implantation of neurostimulator electrodes; autonomic nerve, 64580 Incision for implantation of neurostimulator electrodes; neuromuscular, and 64581 Incision for implantation of neurostimulator electrodes; sacral nerve (transforaminal placement). Code use does not vary from previous years, and 64575 still reports incision for implantation of electrode array for stimulation of peripheral nerves other than the sacral nerve.

G.J. Verhovshek, MA, CPC, is director of editorial development/managing editor at AAPC.

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This past January, the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) published the “Health Care Fraud and Abuse Control Program (HCFAC) Annual Report for Fiscal Year 2010.” This meticulous report of major fraud and abuse attempts, and their resulting penalties, is more than a political gesture to justify the funds associated with the effort, which is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA): It is a look into the future of government constraints on health care fraud and abuse, what they will be targeting, and why. 


Collaborative Investigations Bolster Efforts

The sheer number of agencies involved in fraud and abuse investigative efforts is astonishing:

- The FBI, Office of Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS), and others look at individual physicians, durable medical equipment (DME) companies, hospitals, and extended care facilities for proper practice.
- The Food and Drug Administration (FDA) looks at drug companies for kickback schemes, improper marketing or drug labeling, and clinical trial problems.
- Beneficiaries are scrutinized through the Administration on Aging, Assistant Secretary for Public Affairs, and Civil Rights Divisions for fraud perpetration, enlistment in fraud schemes, and fraud and abuse detection.
- Divisions within the DOJ investigate organized crime and racketeering schemes that defraud the health care system, either directly or through corruption and abuse of private sector and employment-based group health plans.

Several agencies collaborate their efforts through the Health Care Fraud Prevention and Enforcement Action Team (HEAT) and the Medicare Fraud Strike Force, while also working on new technologies and targeted data analysis tools (including modeling tools used in the financial industry) to predict fraud and abuse prior to payment. A partial list of tactics used includes:

- Automated fraud edits
- Establishment of a national data bank of adverse actions
- Unannounced provider and supplier visits
- “Secret shopper” investigations of insurance carriers

As a result, there was an increase in the use of civil monetary penalties in 2010, as well as an increase in criminal fines, recoveries, and compensatory damages.

ROI Is Worth the Expense

With an investment of $577,425,182 for federal agencies involved, $2,862,553,309 was returned to the Medicare Trust Fund. Additional payments were returned to other agencies, for a total of $4,021,727,786. The return on investment (ROI) for the program as a whole since 1997 is $4.90 returned for every $1 spent. The three-year ROI (2008-2010) is $6.80 for every $1 spent. Not bad, as far as federal expenditures go.

Note that many investigations are ongoing, or have not yet been brought to trial. This means we’ll likely see an increase in health care-related civil and criminal cases brought before courts in 2011.
Health Care Fraud and Abuse Covers a Full Spectrum

The following summarizes the numerous problems found in various areas of the health care spectrum:

- Payment of kickbacks (in cash or drugs) and/or threats made to beneficiaries for use of their Medicare information, and to providers for use of their Medicare numbers
- Identity theft of beneficiary and provider/supplier numbers
- Injection and infusion claims (especially of expensive HIV treatments) not medically necessary or not provided
- Physical and occupational therapy services billed but not provided, or not medically necessary

DME issues included:

- DME items not medically necessary, not prescribed, or not provided (especially power wheelchairs, motorized scooters, and other high-end equipment)
- Enteral nutrition supplies not medically necessary, not provided, or substitution of a lower-end product
- Diabetic equipment and supplies not medically necessary

In the pharmaceutical industry, problems included:

- Drug companies misbranding or falsely marketing drugs, paying kickbacks for drugs for off-label indications, or using post-market studies to increase sales
- Underpayment of rebates to Medicaid for drugs by misclassification
- Manipulation of clinical trial data by drug companies and device manufacturers
- Pharmacists submitting claims for prescription drugs not dispensed, charging illegal dispensing fees, replacing medications with lower cost drugs but charging for the higher cost versions, and/or substituting drugs they made themselves that were harmful to patients, and knowingly dispensing dangerous drugs with illegitimate prescriptions
- Medical device manufacturers advising providers to up-code procedures

In the hospital industry, problems included:

- Provision of kickbacks to physicians in the form of rent, increased referrals, increased face time on units to increase their income, and provision of medical directorship payments
- Misrepresentations of outlier payments to increase reimbursements
- Improper billing for inpatient admissions that should have been coded as observation or outpatient visits
- Admissions (including recruiting of patients) that were not medically necessary
- Upcoding diagnosis-related group (DRGs), billing for unsupervised services, and billing for services not rendered or not necessary
- Noncompliance with teaching physician regulations
- Providers submitting fraudulent records to obtain payment, upcoding visits to a higher level than what was rendered, or ignoring co-pays to induce patients into their clinic
- Mental health and nursing home facilities providing substandard care with excluded providers, or falsifying patient records to cover up errors

In the home health industry:

- Overstating services provided
- Improperly trained personnel
- Noncertified home health care or care that was not provided
- Home visits for patients who were not homebound

Government Takes Further Steps in 2011

A final rule promulgated by the Affordable Care Act in CMS-6028-FC, entitled "Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (www.ofr.gov/inspection.aspx) will serve to “cut them off at the pass,” so to speak. Instead of catching the perpetrators after the fact, there will be new rules and technology to prevent the fraud in the first place. For Medicare, Medicaid, and/or the Children’s Health Insurance Program (CHIP), based on fraud and risk levels, these include:

- Establishing new screening procedures for providers of medical or other services and suppliers in the Medicare program, and providers in the other programs
- Establishing an application fee for enrollment to be imposed on “institutional providers” (look closely at the definition) and suppliers
- Establishing temporary moratoria that may be imposed to prevent or combat fraud or abuse under these programs for certain geographical areas and/or for particular provider types identified as having heightened fraud risk
- Establishing state guidance regarding termination of providers from Medicaid and CHIP if first terminated by Medicare or another state plan or CHIP, as well as termination of providers and suppliers from Medicare if first terminated by a Medicaid state agency
- Establishing requirements for suspensions of payments pending credible allegations of fraud in the Medicare and Medicaid programs
- Requesting comments on requirements regarding establishing compliance programs including model compliance programs

The three-year ROI (2008-2010) is $6.80 for every $1 spent. Not bad, as far as federal expenditures go.
Instead of catching the perpetrators after the fact, there will be new rules and technology to prevent the fraud in the first place.

How Will This Affect Your Practice?
Depending on your practice type, many of the new rules might apply and could affect your practice adversely in terms of time, money, litigation, and the development of your compliance plan.

In addition to the rules above, consider how these findings fit in with the overall OIG Work Plan and the issues identified and investigated by the various recovery audit contractors (RACs), Medicare administrative contractors (MACs), and Comprehensive Error Rate Testing (CERT), including:

- Hospital inpatient admissions and readmissions
- Quality of care in nursing facilities
- Overuse of physical and occupational therapy
- States requiring criminal background checks for nursing home employees
- Over coding of services
- CERT oversight
- Payments for services ordered or referred by excluded providers
- Frequency of replacement supplies and medical payments for power wheelchairs
- Medicare pricing for parental nutrition and home blood glucose testing supplies and mail-order strips
- Payments for prescription drugs

All of the above remain part of the OIG Work Plan for 2011 because they were identified in 2010 as excessive areas for fraud and abuse. As for RACs, they also read the current reports and base their focus and data mining on these areas of high cost and high risk for fraud and abuse. Remember, RACs can perform retroactive audits back three years, and they will expand their scope into Medicare Parts C and D, as well.

Issues currently identified by RACs for either automated or complex reviews include:

- Parenteral nutritional supplies more than once a day
- Wheelchair bundling and wheelchair seating with mutually exclusive codes
- Infusion pump issues
- Durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) issued while patient is in a covered acute hospital stay
- Medical supplies and home health consolidated billing
- Prosthetic and orthotic issues
- Units billed for untimed codes
- Inpatient admissions without physician inpatient admit orders
- Acute hospital readmission issues

- Incorrect patient status – acute
- Minor surgery and other treatment billed as an inpatient stay
- Outpatient claims billed during inpatient admission
- Pharmacy supply and dispensing fees
- Drug dosage vs. units billed

These issues, along with an increasing number of medical necessity issues, are found across all four RAC regions. Increased scrutiny of CERT errors will mean closer inspection of requested medical records. Increased analysis of MAC errors means more real-time edits and pre-payment reviews for all provider types.

Take Steps to Combat Fraud and Abuse
If any of these issues pertain to your practice, make sure you perform internal and external audits to ensure you are in compliance. Benchmarking your statistics against others in your industry will help protect you against being caught up in adverse data mining findings. Make sure your practice has a viable, written, and effective compliance plan that is followed closely and revised as necessary.

You also must become even more vigilant that coding and billing is correct, that documentation is complete and accurate, that all orders are entered into the record and legibly signed, and that you answer all additional documentation requests promptly and carefully. Note whether an appeal of the agency’s findings is appropriate.

You cannot stop fraud (although you can report it, if known) so leave this up to the government. But you can stop unintentional abuse by knowing the law and abiding by it. As you increase your efforts to avoid errors, adhere to the Medicare mantra: “The goal of Medicare is to ‘pay claims right the first time.’”

Note: The application fee for “institutional suppliers” who are newly-enrolling, re-validating, or adding a new practice location will be imposed for all applications received on and after March 25, 2011. The cost for 2011 is $505, but will vary from year to year. These fees should be promptly paid upon submitting the application through www.Pay.gov. Once on the site, you must type CMS in the search box under “Find Public Forms,” click on the “GO” button, and click on “CMS Medicare Application Fee.” Fill out the form and submit it (the fields are pre-populated with the correct amount). The government will only accept electronic checks, credit card, or debit from checking or savings accounts. The receipt should then be mailed to the Medicare contractor along with the completed application or the Certification Statement for the enrollment application, if enrolling through PECOS.

Lynn Berry, PT, CPC, had over 35 years of clinical and management experience before beginning a new career as a coder and auditor and later becoming a provider representative for a Medicare carrier. She now has her own consulting firm, LSB Healthcare Consultants, LLC, furnishing consulting and education to diverse provider types. She has held a variety of offices for her local AAPC chapter and continues as one of the directors of the St. Louis West Chapter.
Sylvia Adamcik, CPC, CPC-I, CCS-P

PMCC instructor and manager, Medical Practice Income Plan, Texas Tech Physicians

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

I landed my first job in health care in 1984 as an office manager for a private obstetrics and gynecology (OB/GYN) physician. That also was the year CPT® codes were introduced as general coding requirements for Medicare claims. I thought my role would be interviewing, hiring, supervising staff, keeping books, paying bills, etc.; however, I quickly learned there were a large number of outstanding balances that should have been paid by insurance companies or patients. So, I started working on accounts receivable (AR).

When talking with an insurance company, I was hearing things like “not a necessary treatment,” etc. I didn’t know how to argue with that, so I got a set of coding books and started reading. I taught myself how to code, and began networking with others in similar situations.

I later went to work for a neurology practice; and a few years after that, I worked as a practice supervisor doing inpatient coding/billing for nine OB/GYN physicians at St. Mary’s (now Covenant Health System) Hospital Medical Group. During that time, the medical group offered several of their coding/billing staff an accelerated (10 week) Certified Professional Coder (CPC®) exam course. I took the exam and became certified. I left that medical group in 2005 to work at Texas Tech University Health Sciences Center (TTUHSC) with the coding activities coordinator, pursuing charge capture projects for different department clinics. My employer sent me to the AAPC instructor workshop in Orlando, Fla. where I obtained my CPC-I.

I have since taught the AAPC Professional Medical Coding Curriculum (PMCC) course for TTUHSC and I am unit manager of the Medical Practice Income Plan for Texas Tech Physicians. I assist all departments/specialties in coding education and coding/billing/reimbursement improvements as well as work with our Transaction Editing System and Claim Scrubber to verify that claims submitted are going out as clean and timely as possible.

What is your involvement with your local AAPC chapter?

I first served as secretary, then president-elect, president, president-elect again, and presently president.

What AAPC benefits do you like the most?

I like the opportunity for growth in my profession through education and networking. The knowledge I gain every time I attend a webinar, a local chapter meeting, workshop, or especially an AAPC conference, or read Coding Edge, is invaluable to me. I also feel that my local chapter is family. We are there to support and help one another, both professionally and personally.

What has been your biggest challenge as a coder?

Convincing some administrators and providers to accept coding as a profession, not just a “job,” and that it takes knowledge and skill to be a successful coder that ultimately assists the practice to achieve maximum reimbursement for the services provided.

How is your organization preparing for ICD-10?

We formed a focus group approximately 18 months ago to determine our institution’s needs. I created a presentation that my director and I will be presenting to various clinical department providers and administrators about ICD-10 implementation with a timeline for preparation and training. I also am developing a training program for coders/billers in our institution, aimed at varying levels of experience (i.e., non-certified, certified beginner, certified experienced, and certified advanced levels). We’ll begin this training as the Oct. 1, 2013 implementation date draws nearer. Our implementation plan is a work in progress.

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

I cannot imagine doing another job; however, probably some type of detective. I have always told my students that a good coder is like a good detective—you track down the clues and formulate your answers based on documented facts.

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

My interest in solving mysteries runs over into my free time. I am a huge fan of British mystery series like Agatha Christie’s “Poirot” and “Miss Marple,” and a long running British mystery series called “Midsomer Murders” (similar to “Law and Order”). I also enjoy spending time in Texas Hill Country where we have an RV permanently parked overlooking a lovely valley, where we walk the dogs along the lanes and relax on our deck watching the wildlife.

I have been married for 43 years and have two grown sons and three grandchildren. One son retired two-and-a-half years ago from the U.S. Air Force after serving 20 years. Our younger son and his family live in San Antonio. My husband and I also have four dogs, and two cats. Won’t you please consider adopting a rescue pet? They make wonderful companions!
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