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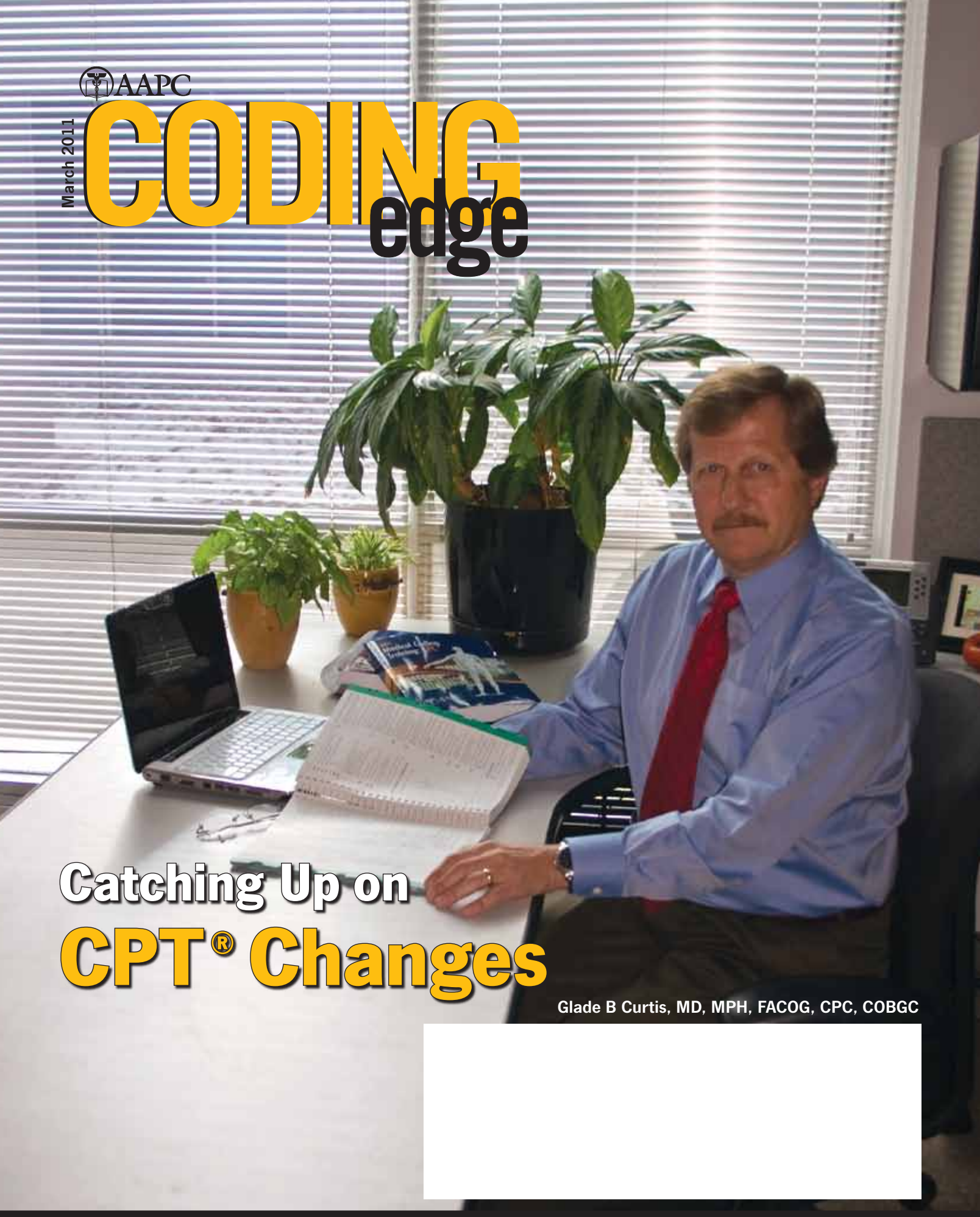

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Glade B Curtis, MD, MPH, FACOG, CPC, COBGC

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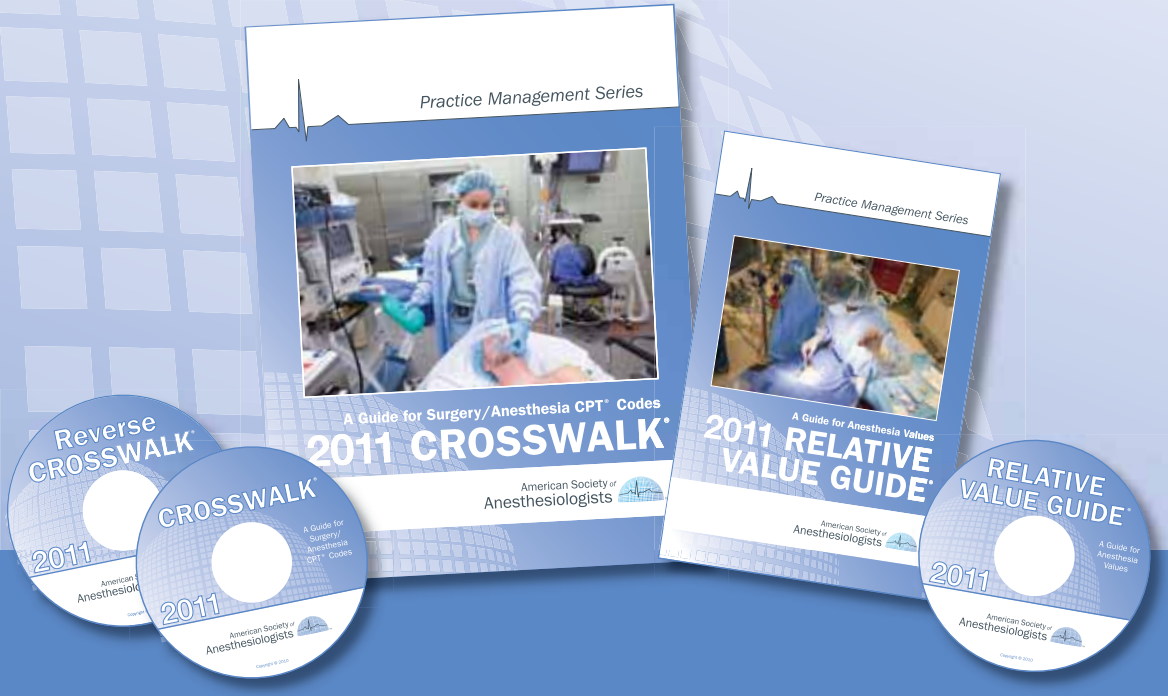

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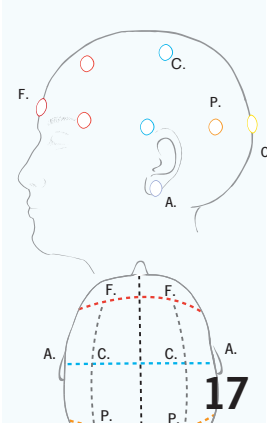

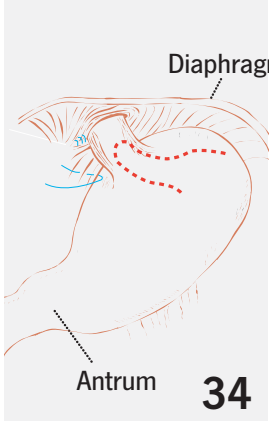

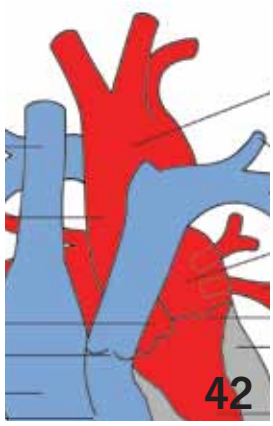

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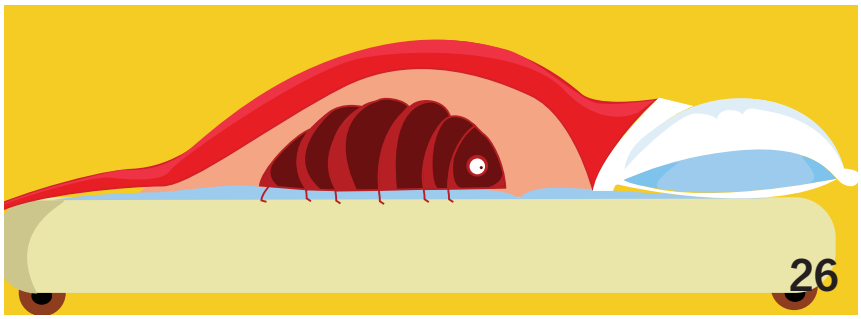

AAPC
CODING edge
March 2011

Features

On the Cover: *Glade B Curtis, MD, MPH, FACOG, CPC, COBGC, reviews this year's changes to CPT® 2011. Photo by Rachel Minson.*

In Every Issue

Special Features

Education

Coming Up

New NAB

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IP-only Procedures

Opthalmology

Stress Tests

Serving 102,000 Members – Including You

Serving AAPC Members

The membership of AAPC, and subsequently the readership of *Coding Edge*, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

APPRENTICE	Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.
PROFESSIONAL	More sophisticated issues including code sequencing, modifier use, and new technologies.
EXPERT	Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

advertising index

AAPC CODING edge
March 2011

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

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Salt Lake City, UT 84170
(800) 626-CODE (2633)

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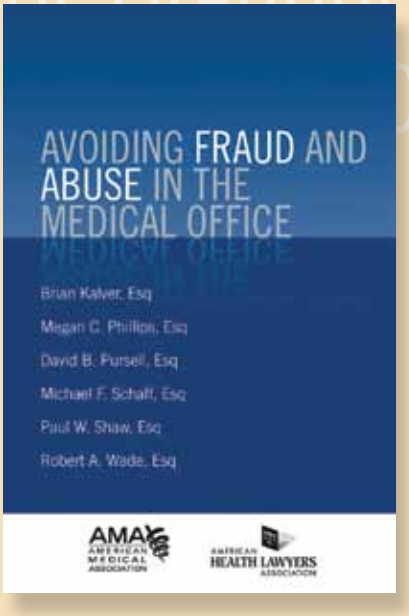

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Networking is Power

I confess: I'm a network-aholic, and I wouldn't be where I am today without the network I have grown and cultivated over time. I have learned so much over the years from my colleagues in the field and I continue to learn from them. I believe networking is empowering, and the backbone of AAPC.

Advance Your Career

Studies show that the No. 1 way to move up the career ladder is by networking. Whether you're just starting out or looking to advance your career, a professional network will enable you to reach unexplored avenues and find great opportunities.

Build Your Network

There are many different ways coders can build a professional network with colleagues. Perhaps the most effective way to build a professional network is to attend AAPC local chapter meetings and national conferences.

- **Local Chapter Meetings:** Every local chapter meeting should have three parts: networking, business, and education. I have met many wonderful people who have enriched my career at local chapter meetings.
- **AAPC National Conference:** These events provide an incredible opportunity to network with people from around the world, in addition to learning vital coding skills and having a whole lot of fun.

A Golden Opportunity

The next AAPC National Conference is April 3-6 in Long Beach, Calif. Come and meet new people from all parts of the country who share the same passion as you—medical coding! Experience the National Advisory Board (NAB) and meet local chapter members from all around the country during "Get to Know Your Local Chapter." Expand your coding knowledge and hone the skills you need in your specialty area by attending the many educational sessions. One of the biggest hits of conference is the Anatomy Expo, where you can learn from physicians who share their expertise.

In addition to the awesome education and networking opportunities National Conference offers, Long Beach is a virtual hotspot. Located in the heart of Southern California, plan on visiting all the local attractions: a deep sea adventure on the bay at the Aquarium of the Pacific, a voyage to the past aboard the historic Queen Mary, and informative guided tours through downtown and the East Village art district. Universal Studios Hollywood, Disneyland, Disney's California Adventure, and all other major Southern California attractions also are less than an hour's drive away.

Regardless of what you come for, you will take away special memories, experiences, and knowledge to remember for a lifetime. Ask any coder who has attended national conference and he or she will agree the conference experience is phenomenal.

If you plan to attend the AAPC National Conference, stop by and say "Hello." Meet your NAB and the AAPC Chapter Association (AAPCCA) board members. We would all love to meet you.

For more information or to register for National Conference, visit the AAPC website at: **www.aapc.com/medical-coding-education/conferences/national/index.aspx.**

If you're unable to attend the AAPC National Conference this year, remember that there are many other ways to network with your friends and peers: Attend local chapter meetings, participate in AAPC discussion forums, and look for regional conference opportunities near you. Take my word for it: Networking will enrich your life and career.

Until next month, my friends,

Deborah Grider,
CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P
AAPC President and CEO

Coding News

Modifier GZ = Automatic Line Denial

Effective July 1, Medicare administrative contractors (MACs), comprehensive error rate testing (CERT) contractors, recovery audit contractors (RACs), program safeguard contractors (PSCs), and zone program integrity contractors (ZPICs) will automatically deny claim line(s) items submitted with modifier GZ *Item or service expected to be denied as not reasonable and necessary.*

Medicare Policy states in Pub. 100-04, *Medicare Claims Processing Manual*, chapter 23 (Fee Schedule Administration and Coding Requirements), section 20.9.1.1 (Instructions for Codes With Modifiers (Carriers Only)), Part E, (Coding for Noncovered Services and Services Not Reasonable and Necessary):

"The GZ modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an Advance Beneficiary Notification (ABN) signed by the beneficiary."

Contractors no longer will perform complex medical review on claim line(s) items submitted with that modifier. An automated edit will be established to deny Part A and B claim line(s) items with modifier GZ appended.

The complete change request (CR) 7228, is located on the Centers for Medicare & Medicaid Services website at **www.cms.gov/transmittals/downloads/R366PI.pdf.**

April Update to 2011 MPFS Database

CR 7319 amends payment files published in the *Federal Register* on Nov. 29, 2010 and Jan. 11, 2011, based on 2011 Medicare Physician Fee Schedule (MPFS) Final Rule. This Recurring Update Notification applies to chapter 23, section 30.1 and is effective Jan. 1, 2011.

To reflect appropriate payment policy with the MPFS Final Rule, some payment indicators and practice expense (PE) relative-value units (RVUs) were revised. New Medicare Physician Fee Schedule Database (MPFSDB) Payment File Revisions were created that include these changes. These HCPCS codes have MPFSDB indicator changes:

93503 Insert/place heart catheter

93224 ECG monit/reprt up to 48 hrs

93225 ECG monit/reprt up to 48 hrs

93226 ECG monit/reprt up to 48 hrs

Effective for claims with dates of service on or after April 1, 2011, HCPCS Level II code Q2040 *Injection, incobotulinumtoxin a, 1 unit* will be added. Additional information on added code Q2040 can be found in CR 7299 (**www.cms.gov/transmittals/downloads/R2147CP.pdf**).

The following HCPCS codes (with short descriptors) have Practice Expense RVU changes:

HCPCS Code	Short Descriptor	Indicator
31579	Diagnostic laryngoscopy	Global Surgery: 000
57155	Insert uteri tandems/ovoids	Co-Surgeons: 2
64613	Destroy nerve neck muscle	Bilateral Surgery: 2
64614	Destroy nerve extrem musc	Bilateral Surgery: 2
77071	X-ray stress view	Bilateral Surgery: 2
92511	Nasopharyngoscopy	Global Surgery: 000
93464 26	Exercise w/hemodynamic meas	Multiple Surgery: 0

The following HCPCS Level II codes are discontinued:

HCPCS Code	Short Descriptor	Termination Date
90470	Immune admin H1N1 im/nasal	December 31, 2010
90663	Flu vacc pandemic H1N1	December 31, 2010
Q1003	Ntiol category 3	March 31, 2011
S2270	Insertion vaginal cylinder	March 31, 2011
S2344	Endosc balloon sinuplasty	March 31, 2011
S3905	Auto handheld diag nerv test	March 31, 2011

For more information see CR 7319, which can be found at: **www.cms.gov/transmittals/downloads/R2150CP.pdf**

AAPC

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Wishing You Continued Success

For those of you who are attending the 2011 AAPC National Conference in Long Beach, Calif., my remarks during Tuesday's luncheon will be somewhat repetitious, but I wanted the opportunity to say these words to the entire membership, not just to those attending the conference.

It's hard for the National Advisory Board (NAB) to believe that our two years are almost over. It truly seems like yesterday when I received the president's gavel and started working with the new NAB and members of AAPC's staff.

Personal Approach to Leadership

Over the past two years, this NAB has attended chapter meetings and workshops, spoken at conference, answered hundreds of e-mails, and (we hope) provided for you whatever you needed from us. We came together as a board twice during the two years to work with and assist AAPC with the future of coding, auditing, management, and billing. At conference, we worked the registration booth and served as the welcoming committee. As a team, this NAB has worked hard and represented our organization and membership well.

My personal goal was to meet each and every one of you, shake your hand, and ask where you were from and your specialty. Although I didn't reach that lofty goal, it was an honor and a pleasure to shake the hands of those many members I did meet. You are my peers and I have appreciated the support you have shown me, the NAB, and AAPC. Although I won't be president, I will continue to meet more of you whenever possible.

I enjoyed the opportunity at conference to make you laugh on Sunday afternoon during coding skits; I went from wearing a patient gown to pajamas to dancing in chaps. My office staff could not believe that was me on stage with the NAB and how comedian Johnny Biscuit loved making a joke of me. NAB did this to show you we are truly real people and your peers. These will be remembered as special times.

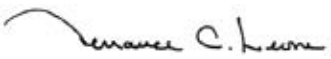
Exceptional AAPC Accomplishments

During my tenure, we realized that the 100,000 member mark was within our reach. AAPC worked hard to help grow membership. We reached it and have continued to grow. It was an honor and thrill to see us cross the 100,000 member status and become the largest coding entity in the world. These are two distinct accomplishments the board and I won't forget. I also realized from the beginning that being the first male president of an organization made up of more than 90 percent female members was not to be taken lightly—I do appreciate that honor.

To **Cynthia L. Stewart, CPC, CPC-H, CPMA, CPC-I, CCS-P**, and the new NAB, I congratulate you and wish you continued success in representing a truly outstanding organization.

It has been an honor and a privilege to be your NAB president. To my board, friends, family, and AAPC staff, I thank you for the support you have shown.

Best wishes,



Terrance C. Leone,
CPC, CPC-P, CPC-I, CIRCC
President, National Advisory Board

Letters to the Editor

Please send your letters to the editor to:
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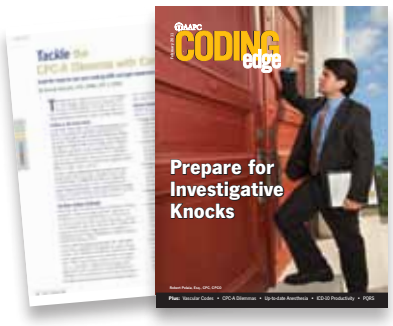

Get the Message Out About the Importance of Coding Credentials

In response to the "Tackle the CPC-A Dilemma with Confidence," by **Brenda Edwards, CPC, CPMA, CPC-I, CEMC**, I applaud her guidance to aspiring and novice coders. Some important points to add are that many medical practices have yet to embrace their need of certified coders and the forthcoming use of ICD-10-CM. Despite certified coders being around for over 20 years, I'm amazed that there are still medical and surgical practices lacking a certified coder on staff. From time spent in payer capacity and sometimes speaking with practice staff, I would ask about a certified coder and one of the more frequent responses sounded like, "I don't even know what that is, so no, we do not have one." That is certainly alarming, especially if you judge the quality of the claims from these practices against a normal, national baseline. I cannot imagine what the quality is there. We, as certified coders and members of AAPC, have the continued responsibility to send out the message to practices: Certified coding staff is essential to health care business. Having our message heard is more important now than ever.

I challenge AAPC to increasing advocacy in this area, tapping providers who lack coders and ensuring an AAPC coder is there to consult on this need and prove our worth.

For those coders who cannot find the job they want, see ICD-10 implementation as your opportunity. Not only is there some evidence that senior coding staff will retire before the inception of I-10, it will become very clear to providers who lack them that credentialed coders are needed.

Kevin B. Shields,
CPC, CPC-H, CPC-P, CCP-P, CCS, CCS-P

Physician, Facility E/M Coding Differs in the ED

January 2011's *Coding Edge* featured two articles about evaluation and management (E/M) leveling in the ED: "Accurately Score MDM in the ED" by **Sarah Todt, RN, CPC, CEDC**, and "Evaluate Your Performance When ED Leveling" by **Jim Strafford, CEDC, MCS-P**; however, these complimentary articles approach a common subject from different perspectives.

Todt's article (pages 22-25)—despite its "facility" label—discusses E/M leveling in the ED for the physician. Strafford's article (pages 46-48), by contrast, considers appropriate methods that a facility may apply to assign E/M levels in the absence of specific Centers for Medicare & Medicaid Services (CMS) guidelines. Note that although the articles reference one another, E/M leveling for the physician and for the facility are *not* equivalent and cannot be compared directly.

When billing professional services to CMS payers, physicians must observe either the 1995 or 1997 Documentation Guidelines for Evaluation & Management Services, which describe physician effort (for example, the level of medical decision-making (MDM), and the amount and complexity of data, etc.). A hospital also may bill for E/M services, but the level is based on the facility resources used rather than physician effort. Because the 1995/1997 documentation guidelines do not consider facility resources, and because there currently are no standard E/M documentation guidelines for facilities, each hospital must develop its own guidelines for E/M leveling, based on CMS recommendations as found in the 2008 Outpatient Prospective Payment System Final Rule (**http://edocket.access.gpo.gov/2007/pdf/07-5507.pdf**).

Coding Edge

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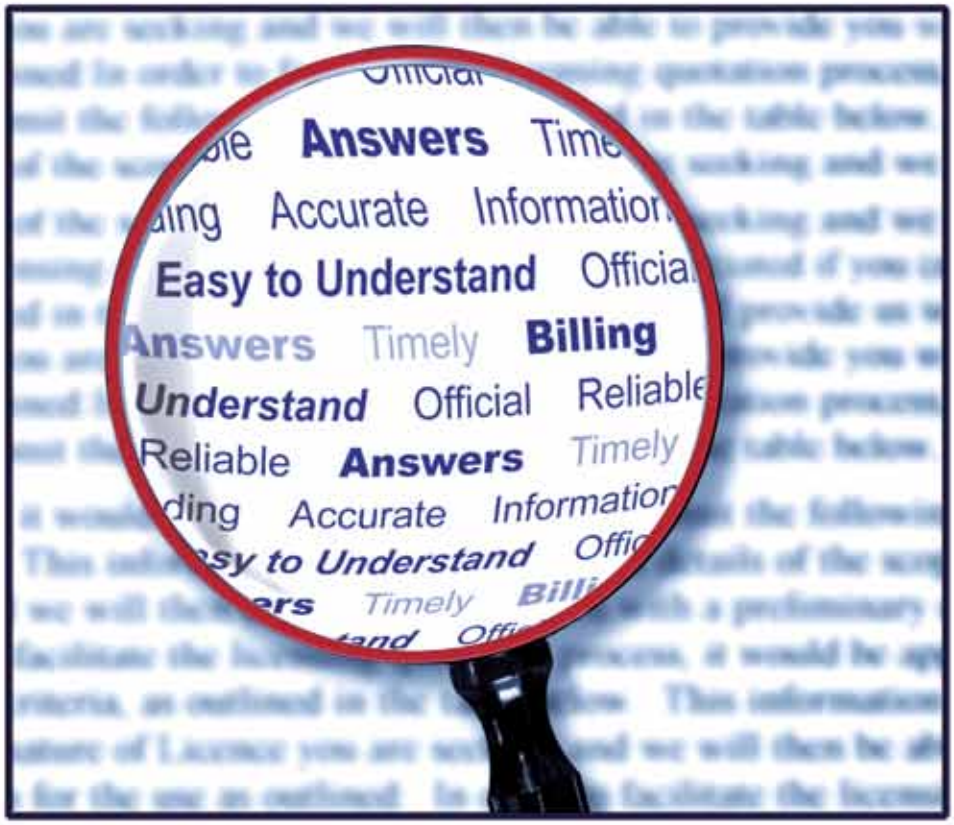

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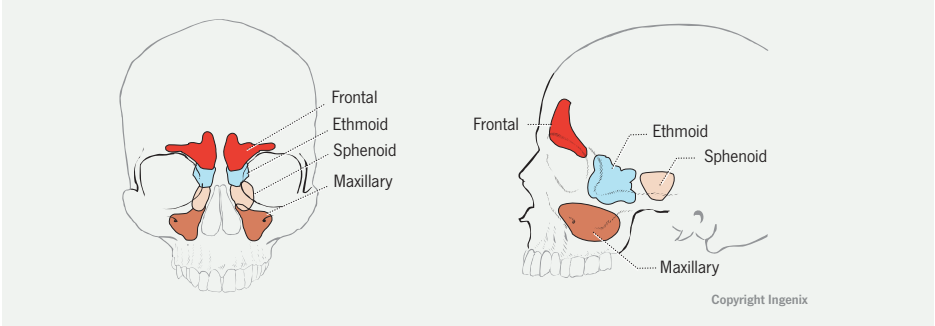
By Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CPC-I, CHCC, CENTC

CPT® 2011
The Latest in ENT Procedures

From bronchoscopy to tongue excision and dizziness to drooling, here's what's new for ENT.



CPT® 2011 brings more than a dozen code changes of particular relevance to ear, nose, and throat (ENT) practices. Among the most prominent is the addition of three codes to report endoscopic dilation of the sinus ostia:

31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa

31296 Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)

31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)

Sinus ostia are narrow corridors connecting the sinuses to the nasal cavity. These pathways can become blocked, allowing sinus secretions to collect, which can lead to sinusitis and other problems. Codes 31295-31297 describe a relatively new technique, in which the surgeon inflates a balloon catheter in the affected ostium (maxillary, frontal, or sphenoid). The expanding balloon forcibly dilates the surrounding tissue. When the balloon is deflated and withdrawn, the ostium remains open. Fluoroscopy, when performed, is included in the dilation.

Like the sinuses, the ostia are paired structures (for instance, there is both a left and a right sphenoid sinus ostia); but per CPT® guidelines, 31295-31297 report unilateral procedures. If the surgeon dilates both the left and right sphenoid sinus ostia, for example, append modifier 50 *Bilateral procedure* to 31297. By contrast, if the surgeon dilates the left sphenoid sinus ostium and the right frontal sinus ostium, proper coding is 31296, 31297. Modifier 50 isn't required because different (rather than paired) ostia were targeted.

When dilation occurs in the same sinus as another surgical, functional endoscopic service, the dilation in some cases may not be separately reportable. Per CPT® parenthetical instructions:

- Do not report 31295 in addition to 31233 *Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)*, 31256 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy*, or 31267 *Nasal/sinus endoscopy, surgical, with removal of tissue from maxillary sinus* when performed on the same sinus.
- Do not report 31296 in addition to 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* when performed on the same sinus.
- Do not report 31297 in addition to 31235 *Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium*, 31287 *Nasal/sinus endoscopy, surgical, with sphenoidotomy*, or 31288 *Nasal/sinus endoscopy, surgical, with removal of tissue from the sphenoid sinus* when performed on the same sinus.

As an example, if the surgeon dilates the left maxillary sinus and performs maxillary antrostomy with removal of tissue in the same sinus, claim 31267 only; the dilation (31295) should not be reported separately. If the dilation and antrostomy occurred at different locations, report each procedure separately, appending modifier 59 *Distinct procedural service* on the dilation code to represent a separate site.

Endoscopic Bronchopleural Fistula Occlusion Calls for 31634

Added code 31634 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed* also describes an endoscopic procedure using a balloon. In this case, the balloon is placed and inflated to occlude (block) a bronchopleural fistula (BPF)—an abnormal passageway between the lungs and pleura that allows inhaled air to escape the lungs into the pleural space. An occlusive substance, such as fibrin glue, may be administered to seal the fistula after the balloon has been removed. The

procedure includes assessment of air leak, fluoroscopic guidance (to guide placement of the balloon), when performed, and moderate sedation.

BPFs occur most frequently due to infection or prior surgery. According to *CPT® Changes 2011: An Insider's Guide*, endoscopic balloon occlusion "has been performed in the past as part of a last effort to resolve persistent bronchopleural fistulas. It is becoming more common as an earlier therapy for this disease." Prior to 2011, the procedure was reported using an unlisted code.

Stereotactic Code Recognizes Extradural Procedures

Image-guided surgery allows for navigation and localization around high-risk anatomical structures. Code 61795, which previously described image-guided surgery, is deleted for 2011 and is replaced by three codes that describe the navigational procedure by location.

New code +61782 *Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)* now describes image-guided surgery outside the cranium. In previous years, there was no way to differentiate extradural procedures from intradural procedures (now reported using +61781 *Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)*) or spinal procedures (now reported using +61783 *Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)*), which generally are limited to neurosurgical specialists.

Navigation is an add-on procedure reported in addition to a primary surgical procedure in the same area. For example, 61782 might accompany nasal surgical endoscopy with optic nerve decompression (31294).

Injection for Sialorrhea — 64611

Sialorrhea (drooling) may be a serious problem for some patients. Selective chemodenervation with botulinum toxin A may reduce saliva production. Code 64611 *Chemodenervation of parotid and submandibular salivary glands, bilateral* describes such an injection into the parotid and submandibular salivary glands. This is a bilateral code; if fewer than four salivary glands are injected, CPT® instructs you to append modifier 52 *Reduced services* to 64611.

Revised Labyrinthotomy No Longer Includes Subsequent Perfusions

Labyrinthotomy may be performed to treat Ménière's disease and/or vertigo. The descriptors for 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* and 69802 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy* have been revised to remove references to cryosurgery. According to *CPT® Changes 2011: An Insider's View*, "Cryosurgery is no longer utilized, and the only type of non-excisional destruction performed currently is the perfusion of vestibuloactive drugs." For example, the physician makes an incision in the tympanic membrane (ear drum), inserts the needle, and perfuses gentimycin (among other vestibulactive drugs) into the middle ear. The perfused drug deadens the hair-like fibers that transmit balance information to the brain. Initially, the procedure may cause dizziness for several days or weeks. This eventually dissipates and the vertigo disappears.

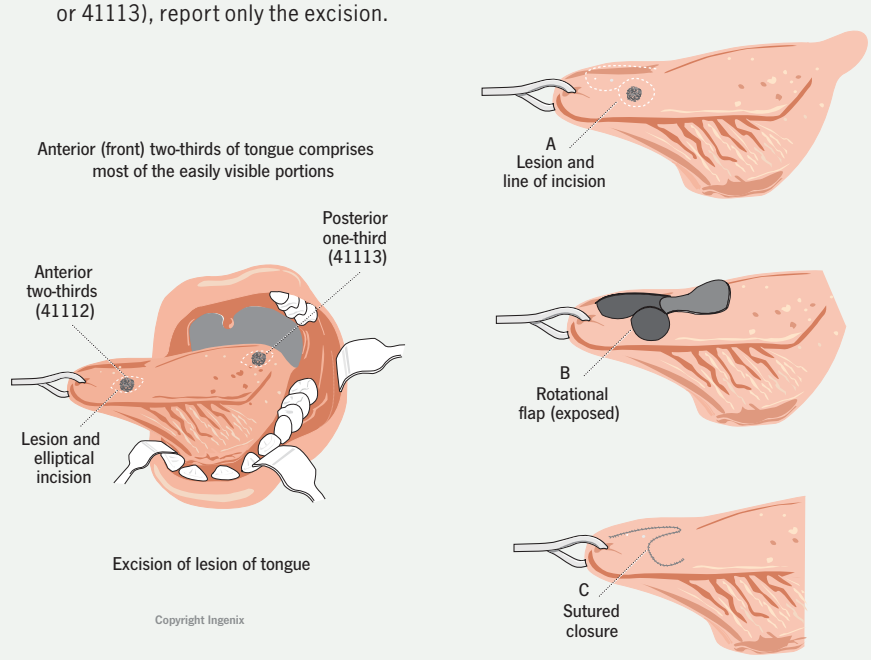
Several treatments may be required. You may report 69801 only once per day; however, for 2011 the global period for 69801 has been changed from 90 days to zero days. As a result, you may report subsequent perfusions on different dates of service separately, along with the drug supply code.

CPT® additionally instructs that you may not report 69801 with 69420 *Myringotomy including aspiration and/or eustachian tube inflation*, 69421 *Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia*, 69433 *Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia*, or 64636 *Tym-*

Watch out for Tongue Excision/Flap Bundle

A revised parenthetical note in CPT® 2011 now disallows separate reporting of **41114** *Excision of lesion of tongue with closure; anterior with local tongue flap* with **41112** *Excision of lesion of tongue with closure; anterior two-thirds* or **41113** *Excision of lesion of tongue with closure; posterior one-third.* This is in direct opposition to earlier editions of CPT®, which instructed "List 41114 in addition to code 41112 or 41113."

Be sure to update your coding. If flap repair (41114) occurs with excision (41112 or 41113), report only the excision.



panostomy (requiring insertion of ventilating tube), general anesthesia when performed on the same ear.

Code 69802 describes labyrinthotomy, as above, along with mastoidectomy (excision to remove an infected portion of the mastoid bone). This procedure is reported rarely (13 cases in 2008, according to **Charles Koopman, Jr., MD**, who presented at the American Medical Association's (AMA's) CPT® and RBRVS 2011 Annual Symposium this past November).

Turn to Category III Codes for Automated Audiometry

CPT® 2011 adds five Category III codes to describe automated audiometry tests (e.g, Tympany Otogram™). Such automated exams diagnose hearing defects using various parameters as defined within the codes.

0208T Pure tone audiometry (threshold), automated; air only

0209T Pure tone audiometry (threshold), automated; air and bone

0210T Speech audiometry threshold, automated

0211T Speech audiometry threshold, automated; with speech recognition

0212T Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated

For audiometric testing using audiometers performed manually by a qualified health care professional, see 92551-92557.

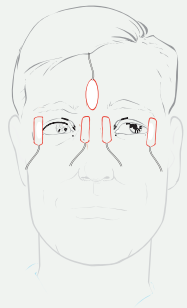
CPT® 2011 Clarifies Vestibular Function Test Combo Confusion

Vestibular evaluations are used to diagnose the origin of symptoms such as dizziness and vertigo, and specifically to determine if something is wrong with the vestibular portion of the inner ear. If dizziness is not caused by the inner ear, it might be caused by brain disorders, another medical condition (e.g., low blood pressure), or even psychological issues (e.g., anxiety).

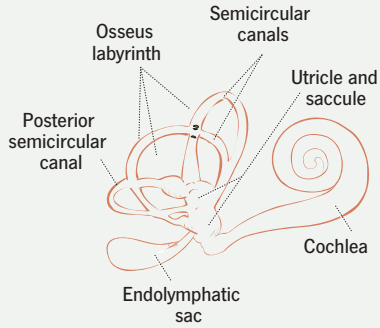
A basic vestibular evaluation includes four components:

- A spontaneous nystagmus test
- A positional nystagmus test
- An optokinetic nystagmus test
- An oscillating tracking test

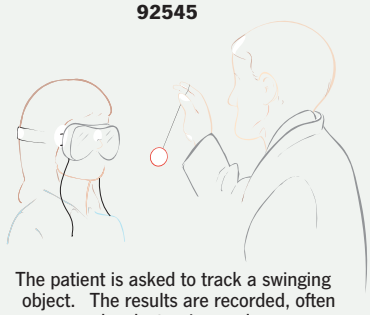
92541



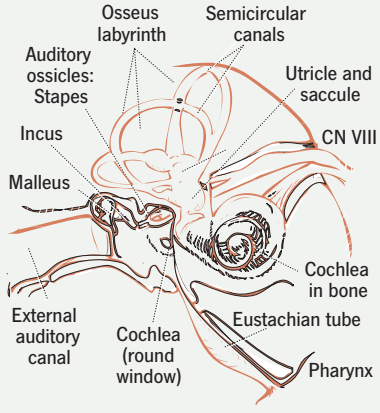
Surface electrodes are placed around the patient's eyes. Or, specialized electronic goggles may be used. The patient's gaze is directed and signs of nystagmus are evaluated. The results are recorded by ENG



92545



The patient is asked to track a swinging object. The results are recorded, often by electronic goggles



CPT® includes codes to report each of these component tests individually; however, if all components are performed together, you would report them using a single code, 92540 *Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording.*

In past years, there was confusion about how to report the individual components of the vestibular evaluation if a complete evaluation was not performed. Parenthetic instructions within CPT® now clarify that if three or fewer of the above component tests are performed, in any combination, you may report each test separately, as follows:

92541 Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording

92542 Positional nystagmus test, minimum of 4 positions, with recording

92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording

92545 Oscillating tracking test, with recording

For instance, for spontaneous nystagmus test and optokinetic nystagmus test, report 92541 and 92544. If these tests occurred along with positional nystagmus and oscillating tracking tests, report 92540 to describe all four components. Don't report any single component (92541, 92542, 92544, or 92545) in addition to 92540.

Note, however, that codes describing caloric vestibular test (92543 *Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording*), vertical axis rotational testing (92546 *Sinusoidal vertical axis rotational testing*), and use of vertical electrodes (+92547 *Use of vertical electrodes (List separately in addition to code for primary procedure)* may be separately reported with 92540 or any legitimate combination (three or fewer) of 92541, 92542, 92544, and 92545.

Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC, is president CRN Healthcare Solutions and senior coder and auditor for The Coding Network. She is consulting editor for *Otolaryngology Coding Alert* and has spoken, taught, and consulted widely on coding, reimbursement, compliance, and health care related topics nationally.

By I. A. Barot, MD

Six CPT® Changes

Reflect the Latest in Sleep Medicine

For 2011, there are six CPT® code changes in the field of neurology/sleep medicine. The additions are primarily the result of the home sleep testing (HST) or portable monitoring (PM), which recently have emerged as a potential lower-cost pathway to screening at-risk patients for sleep-disordered breathing (SBD), including mainly obstructive sleep apnea syndrome (OSAS).

95800 and 95801

Patients with sleep complaints who do not include sleep-related breathing disorders may not be screened with HST/PM (95800 *Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time* and 95801 *Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)*. Even a highly sensitive or accurate portable sleep study fails to detect much beyond obstructive events (apneas, hypopneas). Many HST units are poorly sensitive and may result in false negatives.

A proper protocol for HST would include screening in high-risk sleep apnea patients (snoring, witnessed apneas, daytime sleepiness, etc.), with the intention of treating these patients promptly using auto-titrating nasal continuous positive airway pressure (CPAP) therapy and avoiding excessive testing, if possible. Following such a protocol not only could screen effectively many more patients for OSAS, but also could reduce the health care burden substantially as over 80 percent of SBD patients suffer from non-complicated OSAS. This proactive approach is likely to lower significantly the disease burden of hypertension, cardiac issues, diabetes, obesity, mood disorders, cognitive complaints, and attention deficit hyperactivity disorder (ADD/ADHD), among other commonly-treated conditions (for more information on the link between sleep disorders and other conditions, see "Sleep Apnea: The Not-So-Silent Bed Partner," August 2010 *Coding Edge*, pages 26-27).

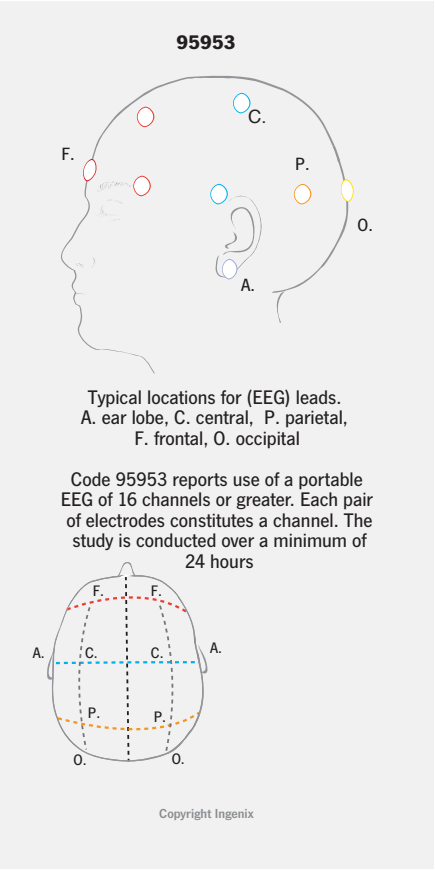
95810 and 95811

For those patients who either have 1) a negative or inconclusive HST with a high pretest probability of OSAS, or 2) a higher pretest probability for either severe or complex sleep apnea, there should be a lowered threshold for a more thorough evaluation, including in-lab polysomnography with proper titration (95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and 95811 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist*).

95953 and 95956

Two CPT® codes have been revised for 2011, and include prolonged seizure monitoring. The first of these, 95953 *Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended*, includes ambulatory recordings that are billed in 24-hour increments depending upon the length of recorded electrocortical activity. Typically, electrodes and sensors are attached to a patient in a neurophysiology lab, data is recorded passively for 24 hours, the patient presses a button if he or she feels an "event" (e.g., possible seizure), and the data is downloaded on a hard drive every 24 hours.

The second prolonged seizure monitor (95956 *Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse*) typically takes place either in an epilepsy monitoring unit (EMU) or in a neurologist's office. Here, the patient is attached to EEG equipment, is observed for 8-24 hours, and the data typically is recorded with both video and EEG interpretation available because this test commonly is done to identify non-epileptic seizures (pseudoseizures), or to localize seizures for potential epilepsy surgery.



Typical locations for (EEG) leads.
A. ear lobe, C. central, P. parietal,
F. frontal, O. occipital

Code 95953 reports use of a portable EEG of 16 channels or greater. Each pair of electrodes constitutes a channel. The study is conducted over a minimum of 24 hours

I. A. Barot, MD, is a diplomat of the American Board of Psychiatry and Neurology and the American Board of Sleep Medicine, a fellowship-trained sleep disorders specialist, director of Sleep Labs at Virginia Neurology & Sleep Centers, and an assistant professor at Eastern Virginia Medical School. He is also a recipient of the Patients' Choice Award and America's Top Physicians Award.

By Sylvia Adamcik, CPC, CPC-I, CCS-P

It's a Good Time to Be Certified

As the physician role evolves, professional coders become more important than ever to reimbursement.

At my age, I know how much the physician office visit has changed over the years, and I have a pretty good idea of what it will be like in the future.

A Simpler Time for Physicians and Patients

As a small girl in West Texas, we had a family doctor who took care of the entire family. He delivered the babies, doctored them into adulthood, and provided elder care and end of life care. He did it all. The staff generally was one nurse and sometimes a receptionist. Many times the nurse *was* the part-time receptionist. The doctor made house calls when a patient was too sick to come to the practice—and that included weekends and holidays.

I remember our family doctor coming to our house early on a Sunday morning to take care of me when I had a bad kidney infection that manifested overnight. He came in his hunting clothes, with his bird dogs in the Jeep. (It was pheasant season and he had been out of town at his family's farm, hunting.) He diagnosed me, gave me an antibiotic injection from his medical bag, and wrote a prescription for oral medication. My mother filled it at the one drugstore open on Sunday for a few hours. By noon, I was in much less pain and feeling hungry. I don't know how much he charged for this home visit, but I know that in those days a visit was just that and there was usually one fee applied, no matter what the circumstance. No one had heard of health insurance. What a huge difference from today's physician practice.

Modern Health Care Is Complex

Now, house calls are rare almost to the point of extinction, and appointments with the family physician are made days, weeks, even months in advance. If an emergency occurs on a weekend, you go to an urgent care clinic or the emergency department (ED) of the local hospital, depending on the severity of the illness. When assessment and treatment is complete, you're told to follow up with your personal physician or a specialist, depending on the condition.

When a patient has an appointment with the family physician, a staff member calls the patient and/or insurance company just prior to the visit to verify coverage, if there is a deductible and if it has been met, and what the co-pay amount will be. When a patient enters the reception area, he or she is:

- Greeted with patient registration forms to be updated.
- Handed Health Insurance Portability and Accountability Act (HIPAA) forms to be read over and attested to.
- Asked to present their health insurance card so a copy can be made.
- In some cases, asked to show a driver's license or some other form of photo ID to verify identity, and
- Possibly asked for prepayment of a copay, if applicable.

EHRs are Changing Health Care

The electronic health record (EHR) system is used to register the patient and notify the nurse/clinician that the patient is in the waiting area. When the patient is called back, the EHR tracking system is activated. Many EHR systems have tracking capabilities to show which room the patient is in, what time they were put in the room, and what time the visit ended. During the encounter with the nurse, nurse practitioner (NP), physician, or other provider the patient's history, examination, and the provider's assessment and plan are entered into the EHR. No more scribbling on a paper chart with illegible handwriting. No more one fee per visit. Each separately billable service is documented so it can be reviewed, coded, billed, and reimbursed as allowed by the patient's health insurance plan.

Doctor Diagnosis Needs Verification

The process of diagnosing patients also has greatly changed. Taking vitals, the hands-on examination, and questioning the patient are all still part of the diagnosing process, but our litigious society dictates that a provider does not risk using just his or her diagnostic skills and training alone. Now, laboratory tests, radiology exams, and other diagnostics are required to confirm that the provider's evaluation of the illness or condition is correct.

What This Means for Coders

When I was a child, there were no procedure, supply, or diagnosis codes to be sent to an insurance company for reimbursement. The doctor provided a service and the patient paid for the service as best as he or she could, either at the time of service or later when the bill came—in installments, perhaps. If a patient did not have the resources to pay, the provider took care of them anyway. Communities pulled together, and physicians shared in the responsibility of taking care of those who were less fortunate.

Today, we have governmental and private programs to give assistance. These programs, like private health insurance plans, require rendered services to be correctly coded and submitted in a timely manner for payment of those services. Submitting services with ICD-9-CM and CPT® codes not only is the source of revenue for providers, it is the source of tracking and trending dis-

eases and conditions in the United States and the rest of the world. For more than 40 years, we have seen the evolution of CPT® and ICD-9-CM codes as medicine and health care have evolved with new illnesses, procedures, and techniques.

Coding Will Factor Into Physicians' Success

Looking ahead, the physician practice will continue to evolve as it transitions to ICD-10, EHRs become mainstream, and the government gets more involved in socialized medicine.

Coders are now, and will continue to be, the pivotal factor for any successful physician practice. In this age of managed care, contractual obligations, and governmental oversight, a physician practice cannot afford to miss any legitimate reimbursement opportunity. To maximize reimbursement, qualified, experienced, certified coding personnel are necessary to help steer the practice in the right direction during these new, unknown, and often very frightening waters.

As a professional coder for many years, I look forward to each new challenge and feel confident in knowing that our profession is growing in knowledge, expertise, and recognition. It's good to be a coder in today's health care world!

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

To maximize reimbursement, qualified, experienced, certified coding personnel are necessary to help steer the practice in the right direction during these new, unknown, and often very frightening waters.

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

Overcome Facility Billing Process Weaknesses

Ensure billing staff members are diligent and adequately skilled in claims administration.

The purpose of facility billing is to submit timely, clean claims to the payer; but the processes that go into filing in a facility claim differ from those on the physician side. Although exact facilities' processes may vary, depending on size and internal structure, many facilities manage the billing process in a similar fashion. We'll provide examples of how facilities manage the billing process and we'll review necessary skills for a facility biller.

Process Begins with the CDM

Departments providing services to patients enter charges to patients' accounts using a charge description master (CDM). This is a large file containing all services supplied by that specific facility. Included is the revenue code, CPT®/HCPCS code (if applicable), and current charge. When the department enters the charge, this information is posted to the patient's account and entered on the UB-04. The site of service determines the exact revenue code; more than one revenue code may be available, depending upon the charging department.

As an example, consider a gastrointestinal (GI) procedure. If the hospital has a designated GI lab, the procedure likely is done in that department, and would be charged under revenue code 0750. If no GI lab exists in the facility, the procedure likely is performed in the minor surgery department and would be charged under revenue code 0360 or 0361 *Operating room services*.

The charging department is responsible for entering the number of units and any drugs and supplies used to perform the procedure. Minor procedures performed in specific labs already may have the CPT®/HCPCS code embedded in the CDM, but major procedures are coded by the coding staff. Inpatient room and care charges are entered by the unit on which the patient is admitted.

Coders and Billers Work at Discharge

When the patient is discharged, the coding staff is responsible for determining the diagnosis and procedure codes, any modifier application, and abstracting the record. Inpatient records also must contain Present on Admission (POA) indicators.

Medicare requires reporting of the POA indicator for all inpatient claims paid under the Inpatient Prospective Payment System (IPPS) in hospitals using Medicare severity diagnosis related groups (MS-DRGs) with a few exceptions. The coder must review all reported diagnosis codes to determine whether that condition was present at the time the physician wrote the inpatient admission order. The purpose is to identify hospital-acquired conditions that should have been avoided, and to determine whether the hospital will receive reimbursement for managing those problems. The four common indicators are:

- **Y**—diagnosis was present at time of inpatient admission
- **N**—diagnosis was not present at time of inpatient admission
- **U**—documentation insufficient to determine if condition was present at time of inpatient admission
- **W**—provider unable to clinically determine whether condition was present at time of the inpatient admission

Facility financial systems usually are programmed to drop the claim a certain number of days after discharge. This action will cause a claim to enter the biller's queue, regardless of whether the claim is correct or complete. For example, if the patient is discharged and the system is set for six days, the claim will be in the biller's queue on day seven.

It is now the biller's responsibility to ensure

charging is accurate and complete before releasing the claim to the payer. Facilities must incorporate hiring standards to assess adequately the biller's ability to make these determinations, based on all entries appearing on the claim. Because the biller is the final person to handle the claim prior to releasing it to the payer, this person must pay strong attention to detail and have problem-solving abilities to manage adequately potentials for rejected/denied and suspended claims. The biller's skills are crucial to effective revenue management.

Claims Scrubbers Are No Substitute for Knowledge

Although claims scrubbers can be helpful in directing the biller to potential problems, they are not a substitute for expertise in billing and payer knowledge. The biller must consider:

- Is the type of bill correct?
- Do the "from" and "through" dates match the number of room charges, if this is an inpatient?
- Do relevant condition, occurrence, and value codes appear on the claim?* If not, the biller will enter this information.

The biller should review all revenue codes on the claim for missing or incorrect information. For example:

- Missing information—For example, revenue code 0370 (anesthesia) and revenue code 0710 (recovery) appear on the claim with no 0360 range (surgery).
- Incorrect information—For example, charges appearing under revenue code 0250 (pharmacy) and 0270 (supplies) are out of proportion to the surgery. An example is a minor surgical procedure with high dollar drugs and supplies.
- Number of units should be reviewed for likely errors.
- Surgery and anesthesia revenue units should be reviewed for likely errors. These services usually are charged in 15 minute increments in a facility. Do these units appear in proportion to the coded procedure?

***Condition codes**
describe circumstances that relate to specific issues affecting claims processing. For example: condition code 07—treatment of non-terminal condition for a hospice patient.

Occurrence codes
report dates that have relevance to the claim. For example: occurrence code 25—date benefits terminated by the primary payer.

Value codes
report information in dollars or units that have relevance to the claim. For example: value code 06—Medicare blood deductible.

- Any applicable modifiers should be present.
- When insertion of devices or implants are described in the procedure code, the charge for that item must also appear on the claim under revenue codes eg, 0275 *pacemaker*, eg, 0276 *intraocular lens*, or eg, 0278 *other implants*. For example, 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)* is reported for cataract extraction with lens implant, one stage. The lens charge also must appear under revenue code 0276.
- The claim should be reviewed for payer-specific coding requirements. Some payers require both CPT® and Volume III ICD-9-CM procedure codes on outpatient claims. Other payers require only CPT® codes on outpatient claims, and may reject the claim if the Volume III codes are reported.
- Any charging and/or coding deficiencies found on the claim should be audited for accuracy before releasing the claim. Although it may not be a hiring requirement, hospitals often utilize a revenue nurse in this capacity to review physician orders, drug administration, and other clinical notes for charging accuracy. Entries to the claim must be corrected prior to submission to the payer.
- The biller should ensure that any applicable authorization codes were entered, as well as correct insured, payer, employer, and physician information before releasing the claim to the payer.

It is critical that employees who are facility billers be much more than data entry personnel. Weaknesses in these staff members' skills result in claims denials, suspensions, and reduced reimbursement. Repeated submission of erroneous claims may invite a payer audit. Rejected claims should be used as a tool to assess the biller's ability to review the charges and other entries adequately. Training should be implemented, as indicated. Examples of repeated departmental charging errors should be reviewed with that department management. The revenue audit nurse is a resource in identifying these service areas. If revenue is to be managed effectively, all staff involved in the charging and billing process must be diligent and adequately skilled in claims administration.

Dorothy Steed, CPC-H, CHCC, CPC-I, CEMC, CFPC, CPMA, CPUM, CPUR, CPHM, CCS-P, ACS-OP, RCC, RMC, PCS, FCS, CPA, is an independent consultant and educator in Atlanta. She was a Medicare specialist for a large hospital system with 34 years of experience in health care. She is a technical college instructor in Atlanta and performs coding reviews for the Quality Improvement Organization in Georgia, performing physician audits and education. She has been a contributor to several medical publications, presented at several health care conferences, and developed training classes focusing on facility billing, coding, and reimbursement.

By Katherine Abel, CPC, CPMA, CPC-I, CMRS

Follow ICD-9-CM Guidelines:

Simplify **HIV** and **AIDS** Coding

MAKE ASSIGNING HIV AND AIDS DIAGNOSIS CODES STRAIGHTFORWARD.

Assigning ICD-9-CM codes for human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) isn't as straightforward as it initially appears. Observing a few simple but very important rules outlined in the *ICD-9-CM Official Coding Guidelines* (section I. C., chapter 1.a) will ensure your diagnosis coding is accurate.

1. V Codes for Asymptomatic Screening

When an asymptomatic patient is seen to determine HIV status, the appropriate diagnosis is V73.89 *Screening for other specified viral disease*. You also may report V69.8 *Other problems related to lifestyle* as a secondary code if an asymptomatic patient is in a known high-risk group for HIV.

2. Report Signs and Symptoms, if Present

When a patient with signs, symptoms, or illness, or a confirmed HIV-related diagnosis, is tested for HIV, you may report the signs/symptoms/illness or related diagnosis, rather than screening V codes. For example, a patient visits the physician for cutaneous lesions on the face and trunk. After biopsy, the physician determines the patient has Kaposi's Sarcoma. The patient is tested for HIV and the results are positive. In this case, report 042 *Human immunodeficiency virus (HIV) disease* and 176.0 *Kaposi's sarcoma of the skin*.

3. Different Codes Apply for Symptomatic, Asymptomatic, and Inconclusive Results

If HIV testing returns positive for a symptomatic patient, report 042.

Assign V08 *Asymptomatic human immunodeficiency virus (HIV) infection* when the patient is HIV positive and does not have any documented symptoms of an HIV-related illness. Do not assign V08 if the term AIDS is used, if the patient is treated for any HIV-related illness, or is described as having a condition resulting from HIV-positive status. In these cases, report 042.

Patients with inconclusive HIV serology, but not a definitive diagnosis or manifestation of the illness, may be assigned 795.71 *Nonspecific serologic test for human immunodeficiency virus (HIV)*.

The HIV counseling code (V65.44 *Human immunodeficiency virus (HIV) counseling*) may be used if counseling is provided for patients with either negative or positive test results.

4. Report Only Confirmed Cases

Do not report HIV if the diagnosis has not been confirmed. In the inpatient setting for facility diagnosis coding, it is appropriate to report suspected or ruled out diagnoses as if the condition does exist. HIV is an exception to this rule: HIV is the only condition that must be confirmed if it is to be reported in the inpatient setting.

Confirmation does not require documentation of positive serology or culture for HIV. The physician's diagnostic statement that the patient is HIV positive or has an HIV-related illness is sufficient.

After a patient has developed an HIV-related illness, the patient's condition should be assigned code 042 on every subsequent admission/encounter. Never assign 795.71 or V08 to the condition of a patient with an earlier diagnosis of HIV (042).

5. Sequence Diagnoses by Relevance

When a patient is seen for an HIV-related condition, 042 is sequenced first, followed by additional diagnosis codes for all reported HIV-related conditions. For example, a patient with AIDS has developed acute myocarditis as a manifestation of AIDS and is being seen in the office for the myocarditis. The appropriate ICD-9-CM codes are 042 as primary and 422.0 *Acute myocarditis in diseases classified elsewhere* as the secondary diagnosis code.

> HIV is the only condition that must be confirmed if it is to be reported in the inpatient setting.

If a patient with HIV disease is admitted for an unrelated condition (for instance, fracture), the code for the unrelated condition is sequenced first. Code 042 is reported as an additional diagnosis, as are any HIV-related conditions. For example, an HIV patient is seen for a sprained ankle. The sprained ankle is coded as the first diagnosis, 845.00 *Sprains of ankle and foot, ankle, unspecified site*. The secondary diagnosis would be 042, followed by additional diagnosis codes for all reported HIV-related conditions. Provider documentation must support the HIV diagnosis.

6. Pregnancy Takes Sequencing Priority

Asymptomatic HIV infection status during pregnancy, childbirth, or the puerperium should be coded using V08 and 647.6X *Other viral illnesses in the mother, classifiable elsewhere, but complicating the pregnancy, childbirth, or the puerperium*. Codes from chapter 15 always take sequencing priority.

When a pregnant patient is treated for an HIV-related illness, the first-listed diagnosis is 647.6x, followed by 042 and the codes for the HIV-related illness.

Katherine Abel, CPC, CPMA, CPC-I, CMRS, is the director of curriculum for AAPC. A prior health care consultant, Katherine has over 15 years of practical experience working in health care, including extensive work with billing offices, insurance carriers, and provider offices. Katherine's experience includes responsibility over coding, compliance, reimbursement, and technology initiatives.

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By Lori Hendrix, CPC, CPC-H, CIRCC, CPC-I

Understand the Value of Networking

Two time AAPC Networker of the Year award winner stresses its importance.

I never realized how networking impacted my life until 2004. I was sitting at the AAPC National Conference enjoying my lunch and listening to the award presentation. I was shocked to realize my name was announced.

What—me, Lori Hendrix from Dallas, Ga., Networker of the Year? I can still remember the excitement I felt that day.

Fast forward to 2010; who would have thought I'd receive a call from Reed Pew announcing that I had once again won this prestigious award for 2009? Sitting in the parking lot at work, I thought how blessed I am.

Networking provides a lifeline of support and information, especially in the coding world. The more you take advantage of networking the greater the benefit you'll receive.

Get Involved

When I stress the importance of networking to other coding professionals, the first question I receive is, "How do I get involved?" AAPC has several venues to utilize.

- **AAPC local chapters.** By committing to attend regularly, you will begin your networking journey. The benefits of taking an active role in AAPC far outweigh any potential concerns or reasons not to become active. Networking is interacting with others for assistance and support. It also can help you develop knowledge and skills.
- **Conferences.** The ultimate networking venue is the annual AAPC National Conference. The conference provides many educational and networking opportunities. I have referred to the conference as the reunion of coders. You reconnect with old friends as well as meet new ones—all while earning Continuing Education Units (CEUs). This year's National Conference is in Long Beach, Calif. on April 3-6.
- **Online.** It is often more convenient to network online than it is in person. This is because you can be exposed to people any time. You also do not have to worry about being nervous or what you look like, as you might if you were in person. From the comfort of your home or office you can decide who you wish to interact with. You also can take your time answering. How many times have you tried to interact professionally in person and were flustered because all eyes were on you?

As a result, something you do not want to say comes out. When you network online, you can eliminate the occurrence of such regretful situations.

There are plenty of places online where networking can take place. Located on the AAPC website (**www.AAPC.com**) are various forums and discussion groups. There are also plenty of social networking sites you can visit. Check out AAPC on Facebook at **www.facebook.com/#!/MyAAPC.**

Benefits Are Limitless

What are the benefits of networking?

- **Growth.** You will grow both personally and professionally.
- **Knowledge.** The more knowledge you possess, the more power you have.
- **Advancement.** By being active in the organization and connecting with other coding professionals, you will advance your career.
- **Information.** Each venue that you attend will provide you with invaluable information.
- **Skills.** Developing skills is a benefit of networking. Networking is a skill in itself. The more you network, the better you do and the more chances there are to grow.
- **Contacts.** You are sure to make great new business contacts and connections.
- **Self-esteem.** People need to socialize and network, which leads to making friends and higher self-esteem. Higher self-esteem makes you happy and in turn makes you create a better position for yourself because people gravitate toward happy people.

Start networking and soon that shy, insecure individual will be in the past. As you conquer your fears and build your networking skills, that person will be replaced by a secure, confident coding professional.

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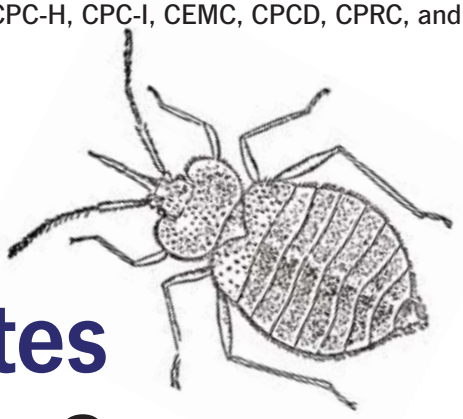
By Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC, and Michelle A. Dick



Treat Bedbug Bites in Two Creepy Steps

First treat the itch, then code the care.

Bedbug infestations can happen just about anywhere: houses, apartments, five-star hotels, college dorms, libraries, movie theaters, retail stores, school buses, and even hospitals. These bugs like to hitch a ride to new, dark, comfortable places. They are nocturnal bloodsuckers that feed just before dawn. Their bites are painless; however, the host may react with skin lesions that need inflammation relief.

Vacuuming, washing linens, and thoroughly cleaning won't eliminate bedbugs, and neither will throwing out a mattress. The bug's oval-shaped, flat body lends itself to hiding in the dark cracks and crevices of beds, furniture, baseboards, drawers, luggage, and even electrical outlet plates; they can hide and nest during the day and easily feed on an unsuspecting host at night.

Health Concerns

Many people are embarrassed by a bedbug infestation, and rather than calling an exterminator, they take matters into their own hands. They apply insecticides in their homes and on their beds without properly reading the labels, which can overexpose them to toxic chemicals. Other people (including landlords) call an expert to find out what insecticide to use and, hoping to save money, buy the insecticide on the Internet, and misuse it. This can be a health risk: Only a licensed professional should treat infestations with insecticides.

The good news is that bedbugs don't spread infectious diseases from one person to another. You can't catch malaria, hepatitis B or C, or HIV from a previous host. "… the potential for viral transmission from the beg bugs to humans is considered to be highly unlikely since the bed bugs lack not only the specific proteins necessary for hepatitis B virus replication, but also the T4 antigen on their cell surface that is required for human immunodeficiency virus replication," according to the Skin & Aging website authors, Philip R. Cohen, MD, Jaime A. Tschen, MD, Floyd W. Robinson, BS, and James M. Gray, MD, (**http://skinandaging.com/con tent/diagnosis-bed-bug-bites**).

The main health concerns are that bites can cause distress, allergic reactions, itching (pruritus), and scratching that can lead to secondary infection. Bedbug bite symptoms may get progressively worse each time a person is bitten. Even if there are no symptoms for the first bite, the second time could result in marks. Strong allergic reaction to bedbug bites can turn into blisters.

How Do You Know if You Have Bedbugs?

Bites appear as circular, red, raised areas around the puncture that may vary in size and pattern. Sometimes they appear in a row. Rows of bites usually are caused by several bugs. They usually bite extremities and areas of the body that aren't covered with clothing. Bedbug bites can be confused easily with mosquito or flea bites, so don't jump to conclusions—if you suspect bedbugs, investigate further:

- Search the area where you just slept. Examine folds and creases in the mattress or sofa, box springs, curtain pleats, behind loose wallpaper, behind molding, and in drawers and luggage. Look on bed linens for dark-brown fecal spots and red blood spots.
- If you find an insect, put it in a plastic bag and compare it with a good reference image, or take it to an entomologist (a bug expert).
- Make sure you have a positive identification before you hire an exterminator. Exterminators can cost hundreds of dollars or more.

Bedbug Victims May Need Medical Attention

Sometimes bedbug treatment calls for medical attention. If an infection forms, antibiotic ointment can be used to treat the affected area. Stronger antibiotics, anti-itch creams, and antihistamines may be used for bites that take longer to heal. Oral antibiotics might be necessary if infection starts to spread.

Presenting Patient

An 18-year-old male presented with a three-week history of pruritic skin lesions on his hands, arms, feet, legs, and face. These multiple, 4 mm to 8 mm red papules appear in the morning and persist for several days. Prior to the occurrence of the lesions, he had moved into a college dorm.

Treatment

The patient's pruritus reaction from the cutaneous bedbug bites was treated systemically and topically. He received loratidine 10 mg each morning and diphenhydramine elixir (12.5 mg to 50.0 mg, as needed) each evening. He also applied a lotion containing menthol 0.5 percent and camphor 0.5 percent (Sarna) several times each day. The lotion was refrigerated to provide additional itching relief.

CPT® Codes

In this example, look to Evaluation and Management (E/M) CPT® codes. The medical decision making (MDM) in this situation would be low to straightforward, and if there was enough documentation you might be able to support moderate MDM. Coding depends on the service rendered, assuming this is an office/outpatient visit. For a new patient, this would be codes 99201-99203 for straightforward MDM, depending on the level of history and exam, or 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity* for moderate MDM and supporting history and exam, which is less likely. For an established patient, the codes are 99212-99214, depending on the E/M and history/exam documented.

Diagnosis Codes

The diagnostic coding will be key to proper reimbursement. Choose diagnosis codes by site and reaction. Because the patient presented with bites on hands, arms, legs, and face, code choices would be:

910.4 Superficial injury of face, neck, and scalp except eye; Insect bite, nonvenomous, without mention of infection

913.4 Superficial injury of elbow, forearm, and wrist; Insect bite, nonvenomous, without mention of infection

914.4 Superficial injury of hand(s) except finger(s) alone; Insect bite, nonvenomous, without mention of infection

916.4 Superficial injury of hip, leg, and ankle; Insect bite, nonvenomous, without mention of infection

917.4 Superficial injury of foot and toe(s); Insect bite, nonvenomous, without mention of infection

If the sites had been infected, you'd use the fourth-digit subdivision of "5" (Insect bite, nonvenomous, infected), rather than "4," for categories 910-919.

HCPCS Level II Codes

Be familiar with the medications your provider has prescribed or administered during the visit. In this case the loratidine is an over-the-counter allergy medicine such as Alavert or Claritin. The diphenhydramine elixir would be written as a prescription, as would the lotion, which is to provide itching relief. In this case, do not code for any HCPCS Level II codes.

Treat the Infestation, Not Just the Bites

To resolve the problem, you must treat the skin reaction and eliminate the bug infestation. In our example, the patient returns to his dormitory and finds numerous bedbugs in the seams of his mattress. Small red and black spots and streaks were seen on the mattress, which were indicative of his blood and bug feces. He contacted his dormitory resident assistant (RA). His mattress was replaced, and the building

ICD-10-CM tip:

Be sure to check your documentation now to be ready for ICD-10-CM. In coding for bedbug bites, it will still direct you to insect bite, (nonvenomous) of location, but your location must be documented. For example:

S60.460x Insect bite (nonvenomous) of right index finger

S60.461x Insect bite (nonvenomous) of left index finger

Hospitals Take Precautions to Stop Infestations

Hospitals have seen a rise in bedbugs over the last year. In all cases, the hospitals took action quickly and hired professionals to remove the bugs.

Bedbugs invaded Bloomington Hospital in Indiana, forcing staff members to quarantine a pair of rooms in November 2010. A patient brought them into the hospital. Officials said the bedbugs were confined to two patient rooms. The rooms were sealed off and heated to 140 degrees in an effort to kill the insects.

Bloomington Hospital spokeswoman, Amanda Roach, said the precautionary measures included:

- Visual inspection of patients before leaving the hospital, after showering, and in a clean hospital gown.
- Staff members heating patients' belongings to kill any bedbugs that may have crawled into clothing, purses, and other items.
- Working with environmental services staff and an exterminator to keep the two quarantined rooms up to the correct temperature to kill the infestations.

Another hospital, Blank Children's Hospital in Des Moines, Iowa, quarantined two patient rooms last October due to bedbugs. A mother noticed them and the hospital took action.

In December 2010, two hospitals in Columbus, Ohio found bedbugs: Ohio State University (OSU) Medical Center and Nationwide Children's Hospital. OSU Medical Center staff received specialized training to identify patients who may have a bedbug infestation at their home. Once identified, patient belongings were isolated and bagged. They called in pest control services to clean and exterminate rooms where bedbugs were found.

Bedbug shown with rice for size comparison

"We looked at patient privacy and patient dignity to make sure that we don't embarrass anybody," stated Director of Safety Michael Gregory.

Nationwide Children's Hospital in Ohio was quick to take care of their bug problem, as well. According to Pam Barber, director of media relations at Nationwide Children's Hospital, they took "proactive efforts to deal with the national bed bug problem," which included "regular use of specially-trained dogs, continuing proactive treatment of high-traffic areas, a hospital-wide policy to contain and treat any evidence or reports of bed bugs, patient/family educational materials, and employee education."

When Kings County Hospital officials feared they had a bedbug outbreak on their hands in July 2010, they closed down the hospital's triage room. Hospital workers suspected a patient with bedbugs had been admitted. Further investigation revealed there were no bedbugs, and the room was reopened.

Michelle A. Dick is senior editor at AAPC.

manager called a bug exterminator to treat the infestation. Within a week, the dormitory was cleared and the skin lesions and pruritus were resolved.

In addition to calling an exterminator to apply insecticides, here are other suggestions that may help to eliminate the problem:

- Encase mattress in a bedbug-tight cover to trap bugs inside, so that bugs can't feed and eventually will die. This treatment may not be successful because an adult bedbug can survive up to a year without a blood meal.
- When discarding a mattress or infested furniture mark it "This has bedbugs," so that others don't inadvertently use it and spread bugs.
- Move the bed away from shelving on walls.
- Coat the bed's legs with a 2 inch (or more) wide band of Vaseline or mineral oil.
- Vacuuming can help to remove bedbugs and their eggs from surfaces, but won't remove them all. Discard the vacuum's contents in a sealed trash bag. Steam clean carpets, as well.
- Caulk cracks in the floor and walls, and glue down loose wallpaper. A professional exterminator frequently is necessary to treat the bedbug infestation.

Sources: Skin and Aging, volume 16, issue 11, November 2008, Philip R. Cohen, MD, Jaime A. Tschen, MD, Floyd W. Robinson, BS, and James M. Gray, MD, (http://skinandaging.com/content/diagnosis-bed-bug-bites) and WebMD (www.webmd.com/skin-problems-and-treatments/features/dont-lose-sleep-over-bed-bugs).

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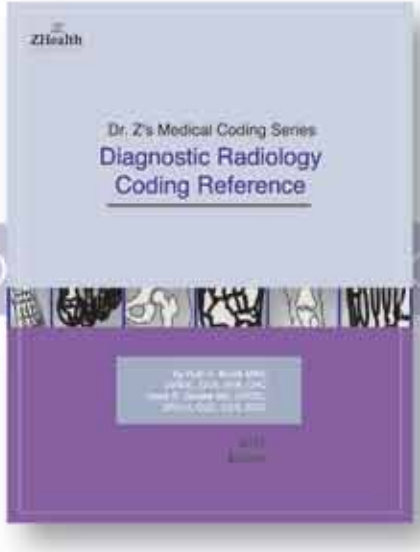

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By Anita Barsalou, CPC

Insurance Fraud:

What's the Real Cost?

Whether it is a staged accident or upcoding a physician service, fraud costs everyone.

Working in the insurance industry for over 27 years has led me to realize just how much insurance fraud costs us as consumers and as a society. This is not a victimless crime. We're all affected by insurance fraud.

Fraud 101

The Association of Certified Fraud Examiners defines health care fraud as, "Intentional misrepresentation of a material (important) fact submitted on, or in support of a claim for payment of a health-care insurance claim, or the theft of money or property belonging to a health plan or health insurance company." Wikipedia defines it more simply as, "Any act committed with the intent to fraudulently obtain payment from an insurer."

U.S. government and law enforcement estimates place the loss due to health care fraud as high as 10 percent of our nation's health care expenditure, or approximately $226 billion each year (see "The Dollars and Cents of Health Care Fraud and Abuse," by Howard Levinson DC, CFE, AHFI).

The number of cases for insurance fraud detected is much lower than the number of acts that actually are committed. Whether you have employer-sponsored health insurance or an individual policy, health care fraud inevitably translates into higher premiums and out-of-pocket expenses for consumers, as well as reduced benefits and coverage. For employers, health care fraud increases the cost of providing insurance benefits to employees, and in turn increases the overall cost of doing business.

There are two main categories of fraud: hard and soft.

Hard fraud occurs when someone deliberately plans or invents a loss. Criminal rings are sometimes involved in hard fraud schemes that can steal millions of dollars. One example is a staged slip and fall. The "victim" hires an attorney, who refers the victim to a physician. The physician submits charges to the insurance carrier, and refers the victim to a physical therapist, who also submits charges. The accident is fake, and so are the "services" the physician and/or therapist provides. Who ultimately pays? You do.

Soft fraud—often called opportunistic fraud—is far more common. This type of fraud occurs when policyholders exaggerate an otherwise legitimate claim. It's that "little white lie" a normally honest person tells the insurance company, such as changing a legitimate date of service from 2/1 to 2/4 with a few pen strokes, and resubmitting the claim. This can be rationalized because "I pay big bucks for insurance, and they did not pay enough on my claim."

Too many consumers believe insurance fraud is justified. According to the Coalition Against Insurance Fraud, two out of five Americans want little or no punishment for insurance cheats. (**http://insurance fraud.org/fraud_backgrounder.htm**).

Consumers blame the insurance industry for its fraud problems because they believe insurers are unfair.

My personal experience suggests that fraud is both widespread and widely tolerated. To cite just one example, a family member on Medicare was charged for a service that was never rendered. When questioned, the office told the family member, "Don't worry about it. You won't be charged for the balance."

Soft fraud isn't harmless. It's a crime that contributes to higher insurance costs for everyone.

The Perpetrators of Fraud

Most commonly, the perpetrators of health care fraud are providers. One reason for this is the historically-prevailing attitude in the medical profession of fidelity to patients. This can lead to fraudulent practices, such as billing insurers for treatments that are not covered by the patient's insurance policy. In other words, a "well-meaning" provider commits fraud to "help" the patient. To do this, physicians often will bill for a different service, which is covered by the policy, rather than what was actually done. For instance, we might see charges for an abdominal hernia repair when a tummy tuck was performed. The Coalition Against Insurance Fraud cites the *Journal of the American Medical Association*, claiming that nearly one-third of doctors exaggerate the severity of a patient's illness to help the patient avoid early discharge from a hospital (**http://insurancefraud.org/learn_about_fraud.htm**).

A tip for coders: Billing non-rendered services usually falls on the shoulders of the billing coder. As coders, you are ethically and morally obligated to code what appears in the notes or records. If you follow that ethic, you cannot be held responsible if a provider falsifies the record (unless you are aware that the records are false). If you're unsure, question the provider and ask him or her to confirm the documentation, and note this exchange within the permanent record. Do not leave yourself open to investigation. A provider, if fighting for his or her financial life, might not think twice about blaming the coder.

Patients deserve their share of the blame for health care fraud, as well. A common fraud technique is to add a digit in front of a charge (e.g., $120 for a blood test that originally was billed as $20.00). Another scheme becoming more popular involves patients who design and submit their own receipts from a provider they have never seen.

On a large scale, law enforcement agencies and health insurers have witnessed the mi-

gration of some criminals from illegal drug trafficking into the safer and far more lucrative business of perpetrating health fraud schemes. According to the Anti-Fraud Resource Center of the National Health Care Anti-Fraud Association (NHCAA), in South Florida alone, government programs and private insurers have lost hundreds of millions of dollars in recent years to criminal rings. Many of these rings are located in Central and South America. These rings fabricate claims from non-existent clinics, using genuine patient insurance and provider billing information that the perpetrators have bought and/or stolen for that purpose.

Other examples of health care fraud include:

- **The billing of late charges by a hospital:** The hospital routinely resubmits a reimbursed hospital stay and claims that "late charges" were not added to prior billing, when in fact there were no late charges.
- **False durable medical equipment (DME) claims:** For example, a manual wheelchair may be billed for a quadriplegic. Although this may seem like obvious fraud, when submitted to a carrier who processes millions of claims, the chances of this slipping under the radar are great.
- **Behavioral health fraud:** One of the most difficult to identify and prove because of constraints surrounding patient privacy.
- **Dental fraud:** Commonly involves submitting for an extraction and replacement of a tooth, and then billing for a restoration on that tooth at a later time.
- **Medical identity theft:** For instance, your wallet is lost or stolen and the person who finds it also finds your insurance card and uses (steals) medical services with your identity. This might establish an unwanted diagnosis on your record or exhaust limited benefits. Identity theft also occurs if we give our card to a friend or relative to use because he or she doesn't have or can't afford health insurance coverage—this is still theft. Our medical insurance cards should be considered as precious as a charge or debit card. If the health insurance card is stolen, report it just as if it were a charge card.

A tip for coders: Many offices, due to the Health Insurance Portability and Accountability Act (HIPAA), require photos on file for each patient. This is a great way to prevent potential fraud and any increased costs to us as consumers.

The Price of Fraud

The cost of insurance fraud is built in to the premiums each of us pay, just as the cost of theft is factored into the amount we pay for consumer products. Higher insurance premiums leave us and/or our employers less money to purchase benefits. Fewer fraudulent charges reimbursed could allow lower premiums and other advantages; maybe your employer could buy a better plan, or reduce the deductable. Maybe the insurance coverage wouldn't change, but there would be more money available for salaries or to fill a position that has been open for a while.

What Can Be Done

What can be done to fight back? Federal and state governments can tighten up fraud laws and institute tougher penalties. There can be an increased sharing of information. The FBI does reach out to insurance carriers to work with them, enabling them to trace a claim from submission to payment. They also may notify a carrier of a current case to verify the carrier's exposure and to see if the scheme had been submitted and reimbursed by that carrier. On a state level, more fraud bureaus need to be established. There are approximately 40 state fraud bureaus now in existence. There should be one for each state.

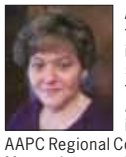
Insurance companies also are responsible for identifying and prosecuting fraud. Most carriers currently have a fraud or special investigations department whose sole focus is to detect, recover and/or prosecute fraud. Most carriers provide information to plan sponsors, members, and their own employees on what to look for so any fraud is identified before money is paid. It is always easier to prevent fraud than to recover illegitimate payments. Insurance carriers do indeed prosecute offenders in an attempt to recoup payments.

Our Role as Coders and Consumers

As coders, we must uphold our ethics. Only code those services that are documented. If you are asked to add a code or service to a bill, politely ask the provider to add it to the patient's permanent record because it is not currently there, and you're sure that he or she would want such information to be part of the record. Don't have fingers of blame pointed in your direction, claiming you are responsible for adding an additional code. Most insurance carriers have a fraud hotline, where cases of fraud can be reported anonymously.

As a consumer, you can be powerful in the fight against fraud. Never sign a blank insurance form; read and understand all claim forms; request detailed bills; check for charges on "free services;" and always keep your insurance identification confidential. Don't be afraid to question or speak up. Remember: The money you save could be your own.

According to the Anti-Fraud Resource Center of the National Health Care Anti-Fraud Association's website (NHCAA), in South Florida alone, government programs and private insurers have lost hundreds of millions of dollars in recent years to criminal rings.



Anita Barsalou, CPC, senior coding consultant for a national carrier, has worked within the insurance industry for 27 years. A CPC since 2005 and a certified ICD-10 trainer, Anita has been a guest speaker at the National Health Care Anti-Fraud Association's training program in Miami, Fla., and at the recent AAPC Regional Conference in Springfield, Mass. Residing in Massachusetts, Anita is currently serving her second year as education officer for her local chapter.

By Melody Irvine, CPC, CPMA, CEMC, CPC-I, CCS-P, CMRS

Eliminate the Interview Jitters

We all have our mild phobias: Some of us fear flying, spiders, or snakes. One phobia almost everyone shares is the fear of job interviews. The pressure to put your best foot forward and knowing that you will be judged by your appearance and every word, may illicit nervousness, sweating, butterflies in the stomach, or worse. As with most things in life, however, preparation helps. Here are some tips on how to look, what to say, the types of interviews you may encounter, and what to do after an interview.

Here Is Where You May Start to Panic

"Hello, this is Dr. Smith's office and we would like to set up a time for an interview. When are you available?"

At this point, you need to focus on the information and instructions they are giving you. Make sure you write down the date, time, and location of the interview. Repeat the information to make sure you wrote it correctly. This phone call could be the first step in identifying if you are a good candidate for the job. It is possible they already are evaluating your grammar, manners, enthusiasm, and ability to follow directions. I do this myself when calling potential candidates.

Be sure your voicemail message is professional, and not silly or inappropriate. Make sure your voice mailbox is not full or unavailable to leave messages. A full voice mailbox could make you looked unorganized and unreliable. If a voice message is left, return the call promptly. If no one is available when you return the call, leave a message confirming that you received their message, and give the best time and phone number to reach you.

Do Your Homework Before

Make sure you know where to go for the interview. Know where you can or can't park, which floor you need to be on, and how long it takes to get there. I recommend driving to the location prior to your interview and think about things that could keep you from getting to the interview on time (i.e., traffic, snow, construction, etc.). If you run late for your interview, this will only add to your stress.

Understanding the process and preparing will help alleviate interview uneasiness.

Gather information about the employer's, most have websites or brochures available. You can make a big impression on the company by discussing and asking questions based on your research.

Dress for Success

Wear black, navy, or brown suits, dresses, or skirts. Suit jackets always look professional whether with pants or a skirt. Make sure your clothing is well pressed and you are well groomed. Do not wear clothing that is too flashy, low cut, too short, or inappropriate for a professional environment. Do not wear too much perfume, jewelry, or make-up. Do not wear high heels if you are not comfortable in them.

Bring What You Need

Take a pad of paper and a pen to take notes, as well as your portfolio. What is a portfolio? A portfolio is a notebook that contains your resume, cover letter, references, letter of recommendation, samples of your work (if appropriate), etc.

Always have copies of your resume and references. It is very frustrating to be given a resume, and then asked, "Can you make a copy because this is my last one?" This is not a sign of good organization.

I also recommend keeping a general information sheet about your work history, employer addresses, wages, etc. Employers may ask you to fill out one of their applications. Have a general information sheet with all your information ready to help you complete the application quickly and completely.

Start the Interview on the Right Foot

Don't be late. Be kind and friendly to the receptionist. The receptionist may be instructed to have you wait, and your interactions with others might be watched. Wait to sit down until you have been invited. If possible, find a chair that does not move or swivel. This will prevent you from fidgeting if you are nervous.

Have a firm handshake. A firm handshake shows you have confidence in yourself. When talking to the interviewer, look him or her in the eyes and speak with passion about what you do. If you have more than one person in the interview process, address your answers directly to the person who is asking the question.

Try to find something in common with your interviewer. Look around the office; does he or she have pictures of dogs, boats, or something else that you have a similar interest in? Try to find that interest without asking too many questions.

Prepare for All Types of Interviews

Testing—Some employers may request you take a coding, billing, or even personality test. These are quite common and typically are not difficult. They want to make sure you have the skills you claim to have on your application.

One-on-one Interview—These are designed to get to know you, your personality, your skill sets, and your background. This interview could determine whether you receive a second interview.

Panel Interviews—Some employers may have a group of people interviewing you from different positions within the company or from a particular department. One panel interview that I underwent was with people from human resources, marketing, coding, billing, education, and other departments.

All of them would work closely with me as an employee, and each person had specific questions that were relevant to his or her department. I was evaluated on how I would work with each department, according to my knowledge, personality, and skills.

Group Interviews—These are becoming more popular with employers. They invite those individuals they feel have the qualifications to attend a meeting. They talk about the practice and their philosophies, how the practice runs, benefits, etc. After the meeting, people who are still interested can submit their information for a chance at a second interview. One of my students recently attended one of these interviews and after the meeting was over, the group was asked to take a test. The test was based on the information given during the meeting. Those who scored well on the test were asked back for a second interview.

A typical interview process may be:

- A call is made to the applicant (employer listens to the tone of voice, politeness, grammar, and enthusiasm).
- An easy test is given to access his or her knowledge of coding.
- If the candidate passes these two steps, he or she is invited to a first interview.
- After all interviews are complete, the final candidates are asked to come in for a panel interview. The panel interview is with the department, and the entire department makes the final decision. By this point, the department knows the candidates have necessary qualifications; now the deciding factor is who they believe they can work with best.

Interview with Confidence

Keep these pointers in mind during the interview itself:

- Remember to say "Yes," instead of "Yeah."
- Don't lie. Always be honest.
- Answer questions with more than one word, but do not ramble on.
- If you don't understand the question, ask the interviewer to repeat it so you don't give an incorrect answer.
- Don't be afraid to ask questions. It is important to interview the person asking you questions. You can find out a little about his or her personality by asking questions such as, "What are your expectations of me?" and "What qualifications are you looking for?" Their answers may help you decide if he or she is the right type of employer you would want to work for.
- Do not ask about benefits, pay, etc., unless brought up by the interviewer. These are questions for the second interview.
- Do not bad talk a former employer. This shows a negative side of you and also can raise questions about your quality of work and integrity.
- Always have a positive attitude and positive answers. If you are not familiar with a subject matter, let the interviewer know you want to learn new things and you like to be challenged.
- Use a sense of humor and—most important of all—be yourself. Interviewers can see right through a person who tries to be someone he or she isn't.
- When the interview is over, thank the interviewer for his or her time, shake hands, and say something the interviewer will remember you by. For example, "I hope to have the opportunity to work with your company," or "I would welcome the opportunity to work with your team." Make it short and sweet.

Nail the Interview Questions

These are common questions that may be asked during an interview:

What are your strengths and weaknesses?

Answer this question in a positive way. Don't say you don't have any weaknesses because everyone does, and it is learning to identify them. When you identify your weakness, follow up with what you are doing to correct your weakness. For example: "My weakness is learning to say 'no.' I get overwhelmed but I am learning to prioritize, which helps me to say 'no' when necessary."

What are your short and long term goals?

Tell me about yourself.

This can be a tricky one. Employers cannot ask you about your marital status, number of children, etc. I have handled this question several ways. At this time in my life, I will talk about my children being grown, that I am married and more about my personal life. I feel it eliminates some of the tip toeing around those questions. When I was a single mom of two small boys, however, I didn't want the interviewer to know that information because I was concerned I would be discriminated against. Discrimination is illegal, but nevertheless occurs.

What does a team player mean to you?

Tell me about your qualifications and skills.

When giving your answer, know the difference between qualifications for the job and your skills.

How do you handle a difficult patient or co-worker?

How would a former employer describe you?

Everyone interviews differently and it's difficult to know what you may be asked during an interview. Some people are not very good at it and are unprepared at interviewing. This is where you can shine if you know how to keep the interview fun and sell yourself.

Impress with an Interview Follow-up

Send the interviewer a hand written "thank you." Many people do not want to be bothered by phone calls. Some do not mind if you e-mail, but a hand written "thank you" is much more impressive.

Don't hesitate to call the company back if you have not heard from them in the time frame they gave you.

If you don't get the job, call the company and see what information they will give you about your interview. Ask them what disqualified you for the position, and learn from this information to make your next interview even better. Ask them to be honest with you, and don't be offended if they are honest—it will only help you the next time around. Sometimes we hear things we don't want to hear, but if we swallow our pride, it will only make us better during the process.

In a competitive environment (not just for this field, but all careers and all professions) the job you are offered may not be the job you are looking for, but don't be picky at the beginning. Most employers promote from within, so take that job and work through the ranks.

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By Marcella Bucknam, CPC, CPC-H, CPC-P, CPC-I, CCC, COBGC, CCS, CCS-P

General Surgery

A shift in paraesophageal hernia thinking changes this year's CPT®, plus what's new with esophagus repairs and hemorrhoids.

The diaphragm repair and esophagus repair sections of CPT® underwent significant revisions for 2011. These changes reflect a shift in thinking about how paraesophageal hernia repairs should be identified, as well as changes in the way they typically are repaired.

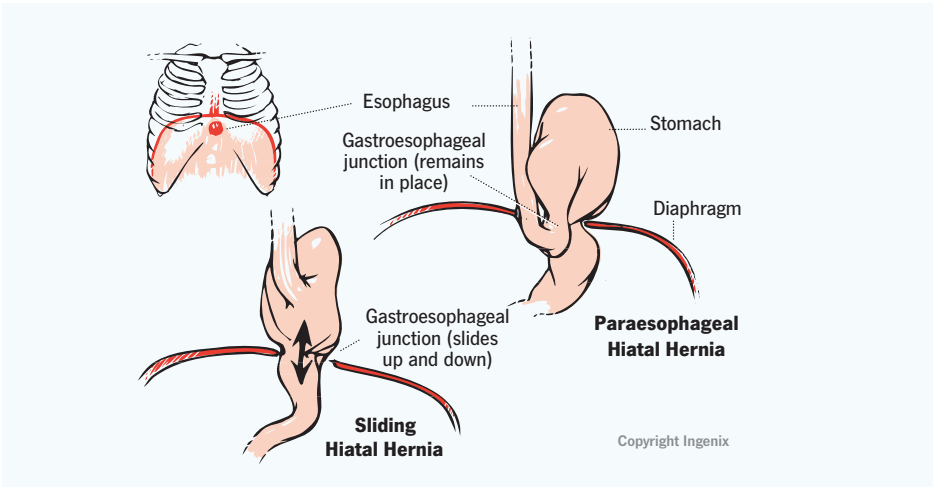
In years past, codes to describe paraesophageal hernia repairs were classified as anatomic disorders of the diaphragm. A new understanding of paraesophageal hernia physiology has caused them to be reclassified as variants of hiatal hernias.

Hiatal Hernia Basics

A hernia occurs when an organ slips through the muscle (in this case, the diaphragm) wall that holds the organ in place. A hiatal hernia occurs when the upper part of the stomach pushes through an opening in the diaphragm, and up into the chest. This opening is called the esophageal hiatus or diaphragmatic hiatus.

There are two categories of hiatal hernias: sliding and paraesophageal.

- A *paraesophageal hernia* occurs when the gastroesophageal (GE) junction remains where it belongs, but part of the stomach is squeezed up into the chest beside the esophagus. The part of the stomach that has moved into the chest cannot return to its anatomic position. There are serious risks associated with this type of hernia.
- *Hiatal hernias* are considered to be "sliding" when the entire stomach, including the GE junction, slides up into the chest. It may slide back into its normal place, as well. Hernias of this type also pose risks, but the risks usually are not as acute as with paraesophageal hernias.



Codes Distinguish Repair Technique

Hiatal hernia repairs involve repairs to the diaphragm, the esophagus, or both. New codes describe treatment of paraesophageal hernia by laparotomy, thoracotomy, or thoracoabdominal approach. Each set of codes includes one code for repair without mesh or other prosthetic and one code for repair with mesh or other prosthetic:

43332 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis

43333 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis

43334 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis

43335 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis

43336 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal, except neonatal; without implantation of mesh or other prosthesis

43337 Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal, except neonatal; with implantation of mesh or other prosthesis

Code paraesophageal hernia repairs by laparoscopic approach with 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* or 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (These codes were added to CPT® in 2010.).

With procedures of this type, documentation should include:

- Approach (laparotomy, thoracotomy, or both)
- Repair of the diaphragm, esophagus, or both with return of the abdominal contents to their normal anatomic locations, if performed

New Codes Replace Diaphragm Repairs

With the addition of 43332-43337, codes 39502 and 39520-39531 have been deleted. The deleted codes included work that is now only rarely performed. For example, 39502 for repair of paraesophageal hernia included vagotomy and pyloroplasty at the time of the procedure because patients often presented with esophageal strictures and gastric ulcers, which would be dealt with surgically. Advances in pharmacology have made strictures much less common. Advances in technology typically allow strictures to be treated endoscopically. As a result, vagotomy and pyloroplasty are performed rarely as part of a paraesophageal hernia repair.

- Placement of mesh or prosthesis, when performed
- Fundoplication, if performed
- Closure

Because the descriptions of the paraesophageal hernia repair codes are so similar in wording, coders may want to highlight or underline the word(s) in each code that sets it apart from the others. For example, in code 43333, coders might highlight as follows:

43333 Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis

One glance at your CPT® book will remind you that this code is for laparotomy approach, doesn't apply to neonates, and includes mesh repair. Don't be afraid to write in your CPT® book so the details that set each code apart can be quickly identified.

Neonatal Repairs Code to 39503

Note that 43332-43337 should not be used for neonatal diaphragmatic hernia repairs. Such repairs still are classified as diaphragmatic hernias, and coded with 39503 *Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia*.

Esophagus Repairs Revised

Esophageal repair codes also underwent significant revision for 2011. Codes 43324 and 43326 have been deleted. Coders are now directed to 43327 *Esophagogastric fundoplasty partial or complete; laparotomy* and 43328 *Esophagogastric fundoplasty partial or complete; thoracotomy* to report esophagogastric fundoplasty—including the popular Nissen fundoplication—by laparotomy and thoracotomy approaches. These codes describe the treatment of gastroesophageal reflux by wrapping part of the proximal stomach around the distal esophagus, tightening the sphincter and also putting pressure to close the sphincter each time the stomach contracts.

Documentation for these new codes should include:

- Approach (laparotomy or thoracotomy)
- Plication of the stomach around the distal esophagus
- Repair of the diaphragm, esophagus, or both with return of the abdominal contents to their normal anatomic locations, if performed
- Closure

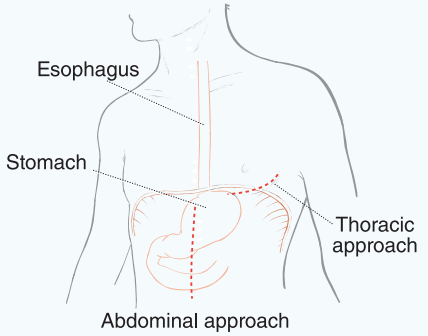
If the approach for one of these procedures is by laparoscopy, choose instead 43280 *Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)*.

Be Alert to Nissen vs. Hernia Repair Differences

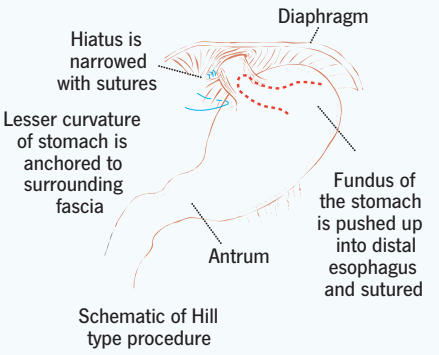
Be aware that the Nissen codes (43227-43328) include repair of any hiatal hernia, and the hiatal hernia codes include any fundoplication. The reason for the procedure should drive code assignment (Nissen for GE reflux, hernia repair for hernia), but in cases where either code could be assigned appropriately, the relative value units (RVUs) are higher for the hernia repair codes. Assign these to reflect the risk and work associated with those repairs.

To illustrate proper coding, consider this sample note for a laparotomy approach to a large hiatal hernia repair, using mesh and a Nissen fundoplication performed at the same time.

43336–43337



43280



Schematic of Hill type procedure

This code reports laparoscopic surgical repair to the area where the esophagus empties into the stomach, the esophagogastric junction. The Nissen procedure involves various techniques to plicate the fundus of the stomach to the distal esophagus. The CPT code is the same regardless of the technique employed

OP NOTE:

DIAGNOSIS: Paraesophageal hernia.

OPERATION(S):

1. Paraesophageal hernia with Veritas mesh.
2. Nissen fundoplication.

INDICATIONS: The patient has a symptomatic paraesophageal hernia. We discussed laparoscopic repair with biologic mesh and a Nissen fundoplication. She understood the risks including recurrence, bloating, dysphagia, and diarrhea, and wished to proceed.

DESCRIPTION: The patient received general endotracheal anesthesia, preoperative antibiotics, and subcutaneous heparin. She was placed in the low lithotomy position with arms tucked and all extremities well padded. She was prepped and draped in the usual sterile fashion. A laparotomy incision was made in the upper midline. We retracted the liver with a paddle liver retractor.

We moved part of the stomach that was not attached in the hiatus from the mediastinum with gentle traction. We then took down the short gastric vessels with an Autosonic scalpel. We divided the hernia sac and the gastrohepatic ligament. We then were able to reduce the entire hernia sac, which was now just attached to the gastroesophageal junction, and placed a Penrose drain around the esophagus.

We then mobilized the esophagus deep in the mediastinum until we had at least 3 cm of intra-abdominal esophagus. We closed the hiatus posteriorly with interrupted 2-0 silk sutures and buttressed it with a piece of 4-ply Veritas mesh cut in a U with the broad-based U fully covering the hiatal closure.

We then marked the posterior fundus, brought it around the esophagus, grasped a mirror image of the anterior fundus, and brought them together for our fundoplication. We placed coronal sutures from the top of the fundus to the right side of the esophagus and right crus and mesh. A similar suture was placed on the left side, and we further fixed the fundoplication to the mesh and hiatal closure where the fundoplication sat naturally.

We then closed the skin incision with 4-0 Polysorb sutures. Sterile dressings were placed, and the patient was extubated and taken to the recovery room in stable condition.

This would be best coded 43333—although it would be acceptable to use 43327. You cannot report the two codes together because each includes both repair of hernia and fundoplication.

Esophageal Lengthening

When the esophagus is too short to appropriately reach through the diaphragm, it may be lengthened by making a tube of the proximal stomach. Staples are placed on each side to narrow the proximal stomach and this additional length becomes part of the esophagus. Two add-on codes, new for 2011, describe esophageal lengthening in conjunction with the fundoplasty and hernia repair codes.

+43283 Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to codes for primary procedure)

+43338 Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)

Code 43283, which describes laparoscopic approach, is to be used only with 43280, 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* and *43282 Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh.*

Code 43338, which does not specify an approach but would be assumed to be for open approach, may be used with open codes 43327-43337, but also may be used with laparoscopic code 43280. This is quite different from most CPT® coding rules. It is recommended that only 43283 be used with laparoscopic procedures, and 43338 be used only for open procedures because the instruction to use 43338 with 43280 may be a typographical error that will be corrected in the future.

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Because the descriptions of the paraesophageal hernia repair codes are so similar in wording, coders may want to highlight or underline the word(s) in each code that sets it apart from the others.

New Hemorrhoid Codes

Also new and of interest for general surgery practice in 2011 is the addition of a new Category III code for hemorrhoid ligation:

0249T *Ligation, hemorrhoidal vascular bundle(s), including ultrasound guidance*

Doppler-guided hemorrhoid ligation, as described by 0249T, is a minimally-invasive technique to treat hemorrhoids that have not responded to traditional banding techniques. Typically these patients have had hemorrhoid banding in the past without success, but this is not a requirement for using the code.

A Doppler device is an ultrasound that allows the doctor to locate the inflamed hemorrhoid(s) and cut off blood supply. When the blood is cut off, the hemorrhoid naturally dries up and no longer exhibits symptoms. The procedure may be performed in the office setting with a two- to three-day recovery time and minimal pain.

CPT® includes a list of codes (such as 46020 *Placement of seton*) with which you should not report 0249T. Do not report 0249T with other codes for excision or ligation of hemorrhoids, unless a different hemorrhoid is being treated using another technique. If multiple hemorrhoids are treated using different techniques, use modifier 59 *Distinct procedural service* to differentiate between the sites.

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Philip Brazao, CPC-A Weymouth MA
Margie Hery, CPC-H-A Wilmington MA
Kim Nelson, CPC-A Wilmington MA
Jennifer Nixon, CPC-H-A Wrentham MA
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Tonie Hines, CPC-A Catonsville MD
Talia Lee, CPC-A Cockeysville MD
Dee Digby, CPC-A Columbia MD
Travis Williams, CPC-A Columbia MD
John Demare, CPC-A Derwood MD
Candice Chapman Gregor, CPC-A Elkton MD
Danielle Zacherl, CPC-A Essex MD
Richard Duncan, CPC-H-A Frostburg MD
Shirley Wong, CPC-A Gaithersburg MD
Ilona Desai, CPC-A Germantown MD
Rajal Kaji, CPC-A Germantown MD
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Lynda Chenowith, CPC-A Manchester MD
Jennifer Saunders, CPC-A Nottingham MD
Kathy DiPeppe, CPC-A Odenton MD
Cynthia Ombogo, CPC-A Owings Mills MD
Vicki Chitwood, CPC-A Randallstown MD
Marsha Welch, CPC-A Rising Sun MD
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Elizabeth Grizzle, CPC-H-A Severna Park MD
Janice Lee, CPC-A Silver Spring MD
Margaret P Herbert, CPC-A Sykesville MD
Joyce Scott, CPC-A Thurmont MD
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Renee Henson, CPC-A Portland OR
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Jamie Magden, CPC-A Tigard OR
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Andrea Riccelli, CPC-A Bath PA
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Jennifer Wise, CPC-A Hermitage PA
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Vanassa Sypher, CPC-A Jonestown PA
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Kevin Quinet, CPC-A Lake City PA
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Evelyn Cimmino, CPC-A Lancaster PA
Carlene Stachura, CPC-A Lebanon PA
Susan Prouty, CPC-A Levittown PA
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Elizabeth Webb, CPC-A Mt Wolf PA
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Jodi Pallerino, CPC-A New Castle PA
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Ruth Buesking, CPC-A Newtown PA
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Julie Devlin, CPC-A North East PA
Joanne Hundermark, CPC-A North Wales PA
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Gina Francis, CPC-A Philadelphia PA
April Folgar, CPC-A Phoenixville PA
Shallegra Deron Moye, CPC-A Pittsburgh PA
Ann Bowman, CPC-A Red Lion PA
Patricia Ann Siciliano, CPC-A Scranton PA
Bonny Lindsey, CPC-A Slatington PA
Paulette Evans, CPC-A South Heights PA
Carol Peters, CPC-A Southampton PA
Regina Schedler, CPC-A Stroudsburg PA
Tammy Mitchell, CPC-A Waterford PA
Angela Martin, CPC-A Willow Grove PA

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Carmen Fencel, CPC-A North Charleston SC
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Ashley Sims, CPC-A Stantonville TN
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Adela Calderon, CPC-A Austin TX
Marisa Guzman, CPC-A Austin TX
Kari Kleman, CPC-A Austin TX
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Van Dinh, CPC-A North Richland Hills TX
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Jeri Dafoe, CPC-A Round Rock TX
Kami Davis, CPC-A Round Rock TX
Joan Kay Gonzalez, CPC-A San Antonio TX
Tammy Harris, CPC-A San Antonio TX
Julia Sierra, CPC-A San Antonio TX
Greta Zaiontz, CPC-A San Antonio TX
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Sharon Smith, CPC-A The Colony TX
Tammie Phillips, CPC-A Weatherford TX
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Lily Barlow, CPC-A Hildale UT
Mildred Keate, CPC-A Hildale UT
Emilie Jeffs, CPC-A Hildale UT
Susan Walsh, CPC-A Ivins UT
Tatiana LiCalzi, CPC-A St George UT
Trudi Janet Prisbrey, CPC-A St George UT
Leslie Simkins, CPC-A St George UT
Emily F Cumbow, CPC-A Abingdon VA
Jaime Nicole Jackson, CPC-A Berryville VA
Stephanie Nicole Tyson, CPC-A Bluemont VA
Rubyn Shaffer, CPC-A Bristol VA
Mary Strickland, CPC-A Chesapeake VA
Letishia Fitzgerald, CPC-H-A Crimora VA
Mandy Jean Tharp, CPC-A Edinburg VA

Julie Crone, CPC-A Fishersville VA
Sarah Black, CPC-A Fredericksburg VA
Judith Lynn Walter, CPC-A Front Royal VA
Patricia L Wright, CPC-A Galax VA
Allison Ferris, CPC-A Goode VA
Brenda C Swanson, CPC-A Green Bay VA
Lindsay Bessette, CPC-A Hampton VA
Debbie Wojcik, CPC-A Hampton VA
Susan Pendergraph, CPC-A Harrisonburg VA
Rebecca Simpkins, CPC-A Hiwassee VA
Cindy P Wilson, CPC-A Honaker VA
Regina H Blevins, CPC-A Marion VA
Melissa Marie Francis, CPC-A Marshall VA
Crystal Lynn White, CPC-A Mt Jackson VA
Nedra Cuffee, CPC-A Norfolk VA
Beverly Ann Morris, CPC-A Norfolk VA
Dreama Lyles, CPC-A Roanoke VA
Edgdallys Hernandez, CPC-A Ruther Glen VA
Katrina Rene Rankin, CPC-A Staunton VA
Phyllis C Painter, CPC-A Stephens City VA
Julie Stewart, CPC-A Stephens City VA
Amelia France, CPC-A Sterling VA
Elizabeth Ann Golden, CPC-A Strasburg VA
Linda Gale Stickley, CPC-A Toms Brook VA
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Sheena Ferrari, CPC-A Bellingham WA
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Michele Gilles, CPC-A Burien WA
Lori Riddle, CPC-A Burien WA
Rachelle Melrose, CPC-A Coupeville WA
Kathy S Adams, CPC-A Edmonds WA
Jennifer Christensen, CPC-A Edmonds WA
Kerri Russell, CPC-A Everett WA
Kathleen Kosmach-Omero, CPC-A Federal Way WA
Stephanie Harlan, CPC-A Mount Vernon WA
Shirley Messner, CPC-A Port Orchard WA
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Sharon Wicklund, CPC-A Puyallup WA
Annette Revert Bovey, CPC-A Redmond WA
Sindhu Pyakurel, CPC-A Renton WA
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Stephanie Sanchez, CPC-A Seattle WA
Susan Huntley, CPC-A Tacoma WA
Nancy Wight, CPC-A Tacoma WA
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Laura Herrick, CPC-A Appleton WI
Cathy Reynolds, CPC-A Milwaukee WI
David Figon, CPC-A Waukesha WI
Vanessa Nicole Costa, CPC-A Clarksburg WV
Tamara Sorenson, CPC-A Kearneysville WV
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Kimberly Koi Kerckhoff,
CPC, CUC Anchorage AK
Maria Salado,
CPC, CEDC Elmendorf Afb AK
Julie A Tanner,
CPC, CPC-H, CPC-P, COSC Bella Vista AR
Angela Marie Thompson,
COBGC Buckeye AZ
Gina Maria Delgado,
CPC, COBGC Tucson AZ
Keri Lynn Campos,
CPC, CEMC Citrus Heights CA
Julie Camozzi,
CPC, CEMC Cotati CA
Saleem A Waraich,
CRHC Fullerton CA
Carrie Moyles,
CPC, CEMC San Francisco CA
Nora Jean Wilson,
CPC, CEMC Santa Rosa CA
Michelle D Worcester,
CPC, CEDC, CEMC Greenwood Village CO
Cathleen A Garcia,
CPC, CANPC Littleton CO
Caroline A Barnett,
CPC-A, CPC-H-A, CPC-P-A, CHONC Hamden CT
Judy A Etgen,
CPC, CGIC Lakeland FL
Tamela S Snape,
CPC, CHONC Matland FL
Brian Connor,
CPC, CANPC Orlando FL
Jeannie Randhan,
CCC Orlando FL
Dana Kathryn Katsikos,
CRHC Ormond Beach FL
Cheryl Yvette Johnson,
CPC, CRHC Atlanta GA
Teresa Wells,
CASCC Bettendorf IA
LeeAnn M Kleiner,
CPC, CEMC New Hartford IA
Linda Patricia Florke,
CPC, CGSC Sioux City IA
Lori-Lynne A Webb,
CPC, COBGC Melba ID
Dora Rae Schweik,
CPC, CANPC Lombard IL
April Renee Jayne,
CPC, COBGC, CRHC Pendleton IN
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CPC, CEDC, CEMC, CFPC Plainfield IN
Tracey Koch,
CEDC Newport KY
Tracy R Tilley,
CPC, CFPC West Paducah KY
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CPC, CEDC Seekonk MA
Jenny Messick,
CPCD Cumberland MD
Izetta Thomas,
CPC, CEMC Rockville MD
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CPC, CANPC Silver Spring MD
Jessica DeBoever,
CPCD Detroit MI
Jennifer Christine Tyler,
CPC, COSC Durand MI
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Gloria Roy,
CPC-H, CASCC Duluth MN
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CASCC Two Harbors MN
Leigh Ann Howe,
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CPC, CCC Clancy MT
Tammy Jo West,
CASCC Kalispell MT
Patricia Gentry,
CPC, CASCC Advance NC
Geraldine Draughn,
COBGC Dobson NC
Deborah Ryan,
CPC, CPRC Durham NC
Melissa Gibson,
CGIC New Bern NC
Kathy Lynn Gammons,
CPC, CPMA, CGSC Pinnacle NC
Deborah Dorton,
CPC, CHONC Southern Pines NC
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CEMC Buffalo NY
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CRHC Great Neck NY
Catherine Rutsky,
CPC, CRHC Hicksville NY
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CPC, CPEDC Ossining NY
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CPC, CPEDC Plattsburgh NY
Darlynn Tate,
CHONC Richmond Hill NY
Verna Pregnon,
CPC, CIRCC, CPC-I, CCC Wappingers Fl NY
Desiree Easterwood,
CPC, CENTC, CPRC Akron OH
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CPC, CEDC Columbus OH
Jessica Dixon,
CPC-A, CEDC Dayton OH
Patricia E Grill,
CPC, CEMC Dublin OH
Kathy Lynn Daniel,
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By David B. Dunn, MD, FACS, CIRCC, CPC-H, CCC

2011 Brings Wide Scale Cardiac Cath Changes

For 2011, CPT® has given cardiac catheterization (cath) coding an "extreme makeover," to include:

- 19 deleted cardiac cath codes (93501, 93508, 93510, 93514, 93524, 93526, 93527, 93528, 93529, 93539-93545, 93555, and 93556)
- 20 new Category I codes (93451-93464 and 93563-93568)
- New injection codes and bundling issues related to congenital cath codes 93530-93533

Familiarizing yourself with the new codes and concepts will help you report these procedures accurately for correct reimbursement and compliance.

New Bundles Abound

CPT® 2011 consolidates radiological supervision and interpretation (S&I), and radiological report, into the heart cath and injection codes. Likewise, all cath codes include placement of vascular closure devices and any associated imaging, when performed. No longer are there separate codes, apart from the applicable cath and/or injection codes, to report these procedures/services.

Non-congenital caths now include left ventricular injections or ventriculography when performed: No additional code is reported for left ventriculogram (Lt. vgram) with non-congenital caths. A number of non-congenital cath codes also now include coronary angiography and bypass graft imaging.

All cardiac cath procedures include conscious sedation, sheath placement, catheter introduction and repositioning, recording of pressures, and intracoronary arterial injection of medications.

Non-Congenital Heart Caths

Now that we know what's included, let's review the new cath codes. We'll start with the 11 non-congenital heart cath codes, and group them for easier understanding:

Note: For ease of understanding, we'll use shortened code descriptors rather than the full CPT® descriptors.

93451 Right heart cath (RHC) only

Note: No coronary angiography with 93451.

93452 Left heart cath (LHC) (+/– Lt. vgram)

93453 LHC + RHC (+/– Lt. vgram)

Note: No coronary angiography, only pressures and Lt. vgram when performed with 93452, 93453.

93454 Native coronary angiography only

93455 Native coronaries + bypass graft imaging

93456 Native coronaries + RHC

93457 Native coronaries + bypass graft imaging + RHC

Note: No LHC with 93454 – 93457.

93458 Native coronaries + LHC (+/– Lt. vgram)

93459 Native coronaries + LHC (+/– Lt. vgram) + bypass grafts

93460 Native coronaries + LHC (+/– Lt. vgram) + RHC

93461 Native coronaries + LHC (+/– Lt. vgram) + RHC + bypass grafts

Add-on Injection and Misc. Procedures

Three add-on injection procedure codes and three add-on miscellaneous codes may be used with the non-congenital cath codes. Imaging supervision is included.

+93566 Right ventricular and/or right atrial angiography

+93567 Supravalvular aortography

+93568 Pulmonary angiography

Note: Code 93566 is for right chamber injections only. Remember that left ventriculogram, when performed, is included in the appropriate non-congenital cath code.

Three miscellaneous codes also may apply:

+93462 LHC by transseptal or transapical approach

Note: Code 93462 is reported in addition to the appropriate non-congenital cath code. It also may be reported with ablations for supraventricular or ventricular tachycardia when a transseptal puncture is made to facilitate the ablation procedure (93651 *Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular trachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other*

atrial foci, singly or in combination or 93652 *Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia*). Code 93462 is *not* reported with congenital heart caths.

+93463 Drug administration (e.g., nitrous oxide) with hemodynamic measurements before and after

Note: This code is *not* for coronary artery drug administration during interventions. Code +93463 may be reported only once per encounter.

+93464 Physiologic exercise study with hemodynamic measurements before and after

Note: This code may be reported only once per encounter.

Congenital Cath Codes

CPT® 2011 retains the four existing congenital cath codes:

93530 RHC only

93531 RHC & retrograde LHC

93532 RHC + transseptal LHC via an intact septum

93533 RHC + transseptal LHC via an existing septal opening

When reporting these codes, keep two points in mind:

1. Do not report +93462 (LHC by transseptal or transapical approach) with 93532 or 93533; the transseptal approach is included in these congenital cath codes.
2. Codes 93532 and 93533 include a retrograde LHC, if performed.

Codes describing injection procedures for congenital caths include:

+93563 Selective native coronary imaging

+93564 Selective bypass graft imaging

+93565 Selective left ventricular and/or left atrial angiography

Note: Although 93563-93565 are to be used *only* with congenital cath codes, three additional codes may be used with *either* congenital *or* non-congenital cath codes:

+93566 Right ventricular and/or right atrial angiography

+93567 Supravalvular aortography

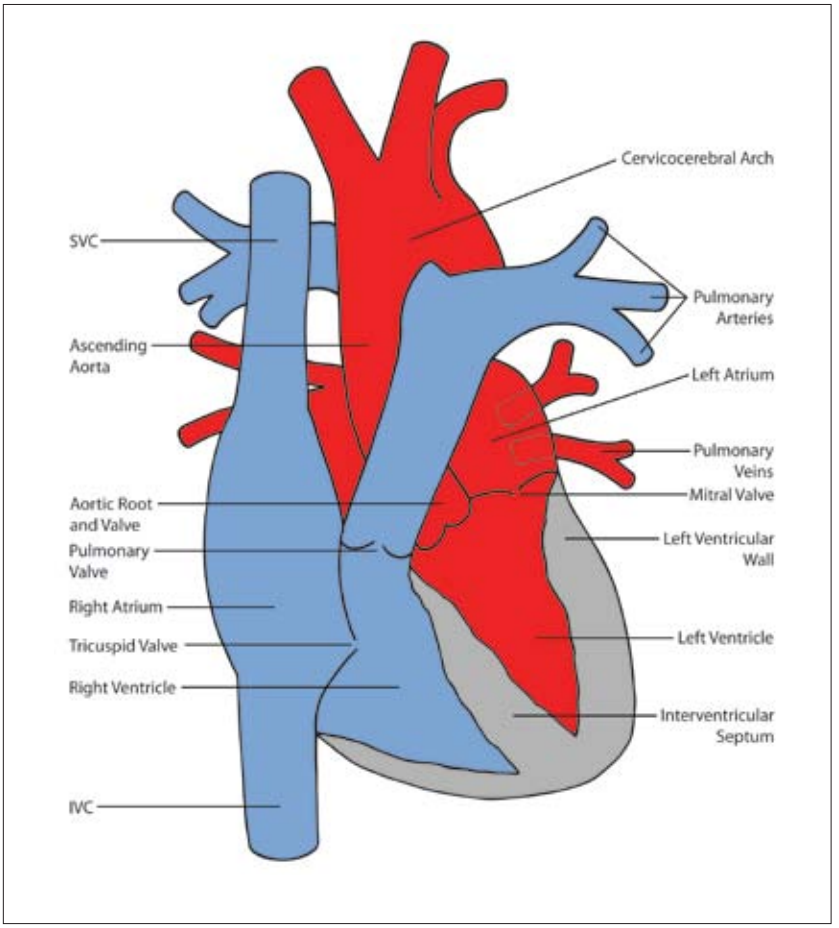
+93568 Pulmonary angiography

Related Cardiology Codes

A number of related cardiology codes may accompany cath claims:

93503 Insertion of a Swan-Ganz catheter for monitoring

Never report this code with right heart cath codes 93451, 93453, 93460, and 93461; placement of the Swan-Ganz catheter is inherent to the right heart cath. Rather, use this code for monitoring a critically ill patient in the intensive care unit (ICU), for example.



93505 Endomyocardial biopsy

Code 93505 is reported only once per session, even if more than one biopsy is obtained. A right heart cath performed for guiding the biopsy would not be reported, but if a complete RHC for separate medical necessity is performed, it may be reported.

93561 Dilution studies with cardiac output measurement

93562 Subsequent cardiac output measurement

Never report these two codes with the right heart cath codes 93451, 93453, 93460, and 93461 because the services are inherent to the RHC. Instead, use these codes during monitoring of a critically ill patient in the ICU, when cardiac outputs are measured.

All 2011 codes include imaging S&I, as well as vascular closure device placement and all associated imaging.

Coding Examples: 2010 vs. 2011

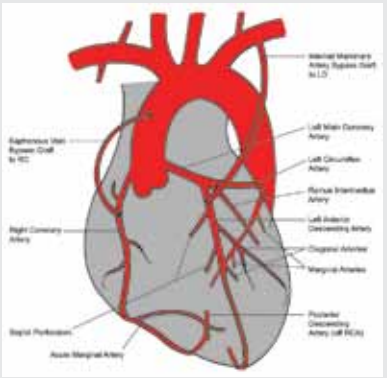
To illustrate how cath coding has changed, let's use two examples to compare coding in 2010 to that in 2011.

Example 1: A patient undergoes a routine left heart cath, coronary angiography, and left ventriculogram.

2010	2011
93510	93458
93543	
93545	
93555	
93556	

This is one of the most common combinations of procedures performed in the cardiac cath lab and, as you can see, the codes reported have gone from five in 2010 to one in 2011. Code 93458 includes coronary angiography, as well as a left heart cath. Like the other non-congenital cath codes, a left ventriculogram is included, when performed.

Example 2: A patient undergoes a left and right heart cath and a coronary angiography, left and right ventriculography, saphenous vein bypass graft imaging, left internal mammary graft imaging, and supravalvular aortography. A vascular closure device was placed at the conclusion of the procedure.



Heart Cath Terminology

Accurate code selection begins with knowing the definitions for common heart cath terminology.

- A *left heart catheterization* (LHC) involves entry into the left side of the heart (left atrium, left ventricle) for pressure measurements.
- A *right heart catheterization* (RHC) involves access via the venous system into the right side of the heart (right atrium, right ventricle, and pulmonary arteries) for obtaining blood samples, and pressure and cardiac outputs.
- *Ventriculography* is the injection of contrast into the right and/or left ventricle(s) to visualize these chambers and to study function of these chambers.

2010	2011
93526	93461
93539	93566
93540	93567
93542	
93543	
93544	
93545	
93555	
93556	
G0269	

In 2011, code 93461 includes the LHC, RHC, coronary angiography; bypass graft imaging including the saphenous vein, internal mammary artery (IMA), and left ventriculogram. Code 93566 is reported additionally for the right ventriculogram, and 93567 is reported for the supravalvular aortogram. All the 2011 codes include imaging S&I, as well as vascular closure device placement and all associated imaging.

Wide scale changes for 2011 are here, but with diligent use of these codes, cardiac cath coding will become easier because fewer codes in general will be required to report each case. It is imperative to learn the new concepts introduced in 2011, and carefully note exactly which procedures are included with each new cath code.

David Dunn, MD, FACS, CIRCC, CPC-H, CCC, is vice president of ZHealth. He oversees physician coding, instructs for ZHealth educational programs, and contributes to Dr. Z's *Medical Coding Series*. A graduate of Texas A&M University, he completed his M.D. at the University of Texas, his surgical residency at Scott & White Hospital, and his vascular surgery fellowship at Baylor College of Medicine. A diplomat of the American Board of Surgery, Dr. 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. He is president-elect of the AAPC National Advisory Board (NAB).

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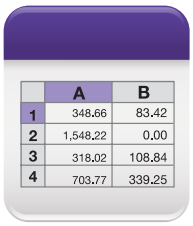

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By Ken Camilleis, CPC, CPC-I, CMRS

3 Immunization Administration Points to Ponder for 2011

For 2011, CPT® codes 90465, 90466, 90467, and 90468—used for reporting immunization administration with counseling—are deleted, and replaced by two new codes:

90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

+90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

When determining whether these new codes apply, consider the following three key factors.

Point 1: Scope of Practice Determines Who Counsels

The purpose of counseling during an encounter for vaccine or toxoid administration is to address concerns or questions that may arise regarding the benefit of a vaccine, or to allay fears about side effects of a particular agent. Counseling may be provided to a child and his or her parents, or other family members, caregivers, or anyone else responsible for the child's well-being when presenting for vaccinations.

Deleted codes 90465-90468 specified within their descriptors, "when the physician counsels the patient/family." This commonly was interpreted to mean that *only* a doctor of medicine (MD) or a doctor of osteopathy (DO) was qualified to report these codes—although, some observers interpreted "physician" more broadly to include mid-level providers.

To reduce this confusion, 90460 and 90461 now have replacement language that specifies, "counseling by physician *or other qualified health care professional*." A question remains, however: What constitutes a "qualified" health professional? The answer largely is determined by scope of practice regulations, which vary from state to state.

Scope of practice is a concept defined by state licensing boards to identify services that a licensed individual is authorized to perform legally, based on that individual's pertinent education and experience. This means each state's scope of practice provisions determine whether a medical practitioner is qualified to provide (and bill for) counseling in relation to pediatric/adolescent immunization administrations.

There are three distinct groups of health care practitioners that provide medical services: top-level providers, mid-level providers, and auxiliary (ancillary) staff. Top-level providers are board-certified. In any state, a top-level provider such as an MD or DO can report counseling of patients or parents for an immunization if the counseling is documented properly in the patient's medical record.

Mid-level providers have at least a bachelor's degree in medicine or nursing. Examples are:

- Advanced nurse practitioners/advanced registered nurse practitioners (ANPs/ARNPs)
- Clinical nurse practitioners (CNPs)
- Registered nurses (RNs)
- Physician assistants (PAs)

Based on their education, CNPs, ANPs, ARNPs, and RNs would qualify under scope of practice criteria to report 90460 and 90461. Depending on the payer, however, the mid-level provider may be reimbursed at less than the relative value unit (RVU) or contracted rate, per Medicare's incident-to provision. Mid-level providers other than CNPs, ANPs, ARNPs, and RNs may be governed by their state's scope-of-practice laws as to whether they may report 90460 and 90461, or whether they may report only immunization without counseling (90471-90474).

Auxiliary staff, such as licensed practical nurses, nursing assistants, and other medical staff assistants, may have no formal degree. According to AAP, such clinical staff *does not* qualify as providers who may report vaccination counseling services.

My recommendation when coding any pediatric or adolescent vaccine or toxoid administration with counseling is that documentation clearly identifies *who* (including title(s)) provided the counseling to parents, with proper signatures to verify the level of provider qualification. I also recommend that providers and coders periodically visit their state government's website and search under their insurance division to remain abreast of scope-of-practice regulations for mid-level providers, with regard to reporting and reimbursement of 90460 and 90461.

Point 2: Vaccine/Toxoid "Components" Are Separately Coded

Secondly, consider the meaning of the word "component" in the descriptors for 90460 and 90461. According to the AAP, a component refers to all antigens in a vaccine that prevent diseases caused by one organism. Combination vaccines are those that contain multiple components. The extra practitioner work involved in administering multiple component vac-

cines/toxoids is considered and *each component is reported separately.*

For example, a DTaP consists of three components (diphtheria, tetanus toxoid, and acellular pertussis) so the reporting of DTaP with counseling would be:

- 90700 *Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use,* for the vaccine itself
- 90460 for administration with counseling of the first component (diphtheria)
- 90461 x 2 for administration with counseling of the second and third components (tetanus and pertussis)

Note that the first component code (90460) resets within the same claim if more than one vaccine is administered. For example, a 5-year-old boy was administered DTaP and MMR with parent counseling. In this case, the coding for the DTaP would be (in no particular order, but depending on the payer): 90700, 90460, 90461 x 2; and for the MMR:

- 90707 *Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use*, for the vaccine itself
- 90460 for administration with counseling of the first component (measles)
- 90461 x 2 for administration with counseling of the second and third components (mumps and rubella)

Point 3: Patient Age Affects Coding

Previous immunization with counseling codes 90465-90468 applied to patients younger than eight years of age. New codes 90460 and 90461 apply to all patients "through 18 years of age," or up through the day before the patient's 19th birthday.

As in the past, if a patient of any age presents for vaccinations, but there has been no billable counseling, the administration(s) must be reported with codes 90471-90474.

Based on information on the American Academy of Pediatrics (AAP) website, counseling (90460/90461) and non-counseling (90471-90474) immunization codes may be reported together; however, both the AAP and the Centers for Disease Control and Prevention (CDC) recommend that a physician or other qualified professional counsels patients and family about the risks and benefits of all vaccines administered at a particular setting, including discussions of previous side effects, the potential impact of a new illness, and possible contra-indications to the administration of an agent.

Kenneth Camilleis, CPC, CPC-I, CMRS, is a medical coding and billing specialist whose present focus is coding education. He is a full-time PMCC instructor and part-time educational consultant. Last year he was the education officer for his local chapter.

By Freda Brinson, CPC, CPC-H, CEMC

Dissect AAPC's Local Chapter Handbook

This completely obsessed reader walks you through it.

How would you describe a typical coder? It is pretty close to impossible because a coder can be as young as a high school graduate or of retirement age. A coder has no limits and there is no such thing as a typical coder. We are all unique.

The same holds true for our local chapters. Even though we are AAPC chapters, there could be significant variances from one local chapter to another. Being different and unique is usually a good thing, but when it comes to an organization's policy and rules, we all need to be on the same page—and that's where the *Local Chapter Handbook* comes in.

Best Handbook You'll Ever Read

The *Local Chapter Handbook* could very well be one of the best handbooks you'll ever read. If you are laughing right now, then you know me and the handbook pretty well. If you are stunned, then you have never read the handbook. Contained within its 52 pages are the answers to almost every AAPC chapter-related question. Each year, an AAPC Chapter Association (AAPCCA) committee reviews and updates the handbook to provide the answers to your questions. For AAPC to be successful, its local chapters must also be successful. Providing each local chapter with the tools and information for success is what the handbook is all about.

Here are some questions for which you can find answers in the handbook:

- Want to know about chapter elections? See chapter 6.
- Want to verify that you have what it takes to be a chapter officer? See chapter 5.
- Want to know about chapter finances? See chapter 13.
- Want more information on continuing education units (CEUs) and your chapter meetings? See chapter 7.

Together, let's walk through the handbook. You can find it online at **www.aapc.com**; log-in and click on My AAPC, then My Chapter. The link for Local Chapter Handbook will be on the left.

Get to Know the Handbook

Chapter 1—Our Mission

The handbook starts with a general welcome and introduction of who and what AAPC, AAPCCA, and your local chapter are. Here, you'll find mission statements and learn the purpose of AAPC local chapters is "to promote the profession of coding and ultimately to promote the AAPC mission of 'Upholding a Higher Standard.'" The mission is:

5.1—Promote and expand the medical coding profession

5.2—Provide an educational forum for AAPC members to receive low cost or no cost CEUs

5.3—Offer an opportunity for networking among AAPC members

5.4—Establish an environment where less experienced members may interact, learn and be mentored by those members with more experience

5.5—Proctor AAPC certification examinations

Chapters 2–5—Officer Expectations, Responsibilities, and Roles

Chapter 2 describes how local chapters come to be and what is required of and expected from chapter officers.

Chapter 3 expands on chapter officer information by listing what positions are required within the chapter and ends with the benefits of serving as an officer.

Chapter 4 continues with officer expectations and what qualifications an officer nominee should possess.

Chapter 5 details each officer role, discusses record retention requirements for all chapters, and the annual leadership training offered by the AAPC Local Chapter Department. Should your chapter have to change an officer in the middle of term, you can find out how to do it under 12.1.

Chapter 6—Elections

Local chapter elections are exciting, somewhat challenging, and a vital part of local chapters. It is the beginning of new ideas, new member involvement, and new direction. Chapter 6 outlines everything you

need to know about elections. There is information on how to prepare, how to nominate, what the term limits are, how to create ballots, and what to do after elections are held. Also in this chapter are suggestions for what your newly elected officers should do at their first officer's meeting.

Chapter 7—Local Chapter Meetings

Chapter meetings are a fun place to be. Chapter 7 provides you with information on what chapter meetings are. As explained in 2.1, "The purpose of local chapter meetings is to educate and network with other coding professionals." This chapter also explains how to apply for and offer CEUs at your meetings, the difference between Curriculum A and Curriculum B CEUs, local chapter seminars, and local chapter review classes.

Chapters 8–10—Certification Exams

These chapters are devoted to AAPC certification exams. Most of you have taken exams but few have proctored them. Proctoring is a very rewarding experience. As a proctor, you can create a calming atmosphere for soon-to-be certified coders. Proctoring ensures continued success of our profession and the organization we are a part of.

For those who have local chapters near Professional Medical Coding Curriculum (PMCC) sites, chapter 10 guides you in developing those relationships.

Chapter 11—Chapter of the Year Award

If you are interested in becoming AAPC Chapter of the Year, chapter 11 is for you. If you make it a goal for your chapter, you can achieve it. Start by reading this chapter. Study what it takes to be eligible, review the Additional Points information, and then set out to accomplish these things. This may require some planning and a little extra work, but your chapter will grow as you work to achieve this goal.

Chapter 12—Marketing and Promoting

If you need AAPC marketing material to help promote a chapter meeting, chapter 12 can help.

Chapter 13—Finances

The final chapter of the handbook is an important one: Financials. While this is intense, it is a **must read** for both chapter officers and chapter members. This chapter explains what should and should not be done with chapter funds, how chapters are accountable for these funds, requirements of chapter checking accounts, and how to receive chapter quarterly reimbursement.

The three appendixes include required chapter forms, the Summary of Infractions/Consequences, contact information for AAPC and AAPCCA links.

In cases where you have a question that is not addressed in the handbook, there are several options:

1. Contact the AAPC Local Chapter Department. Marti, Linda, Kay, and Emilie are some of the nicest people you will ever speak with and they are always ready to help.
2. Contact the AAPCCA. Each of our eight regions has two members assigned who would love to receive your call (or e-mail). We are in these roles because we want to help local chapters and make a difference.
3. Ask your fellow AAPC members by posting your question on the forum. It may be the answer *is* in the handbook and you just can't find it. Someone on the forum may know the answer. Keep in mind that you should verify forum responses with the handbook.

The bottom line is: If you have a question that is not addressed in the handbook, we want to know. There could be another member who has the same question. We want to hear it so we can address it and add the information to the handbook.

Read the handbook and you may become passionate about it like me. You, too, will be known as a "completely obsessed handbook reader."

Freda Brinson, CPC, CPC-H, CEMC, serves on the AAPCCA board of directors and is compliance auditor for St. Joseph's/Candler Health System in Savannah, Ga. Freda has 30 years of health care experience, ranging from receptionist to office management for physician practices and charge description master and charge auditing in the hospital setting. She was the 2008 AAPC Networker of the Year and chapter president when Savannah was named 2008 AAPC Chapter of the Year.

Project AAPC: Help Feed America

Last year, Project AAPC was a huge success! The funds raised by the local chapters were donated to the American Red Cross for flood ravaged Nashville.

The mission of Project AAPC is to support those in crisis. This year we are looking at a much larger crisis in America, HUNGER.

Feeding America (formerly Second Harvest) serves over 37 million people a year through their network of food banks nationwide. We know that our members care about their communities and this is a way to give back to those in need.

It's time for your local chapter to get creative and organize some fundraisers for Project AAPC. Your local chapter donations can then be turned in at the AAPCCA booth during the conference in Long Beach where you will receive the coveted "Project AAPC" Ribbons for your chapter members. It will be an exciting time to see what the local chapters can do Together!

Geanetta Johnson Agbona, CPC

Medical Billing and Coding Instructor at Southeastern Institute, Charlotte, N.C.

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

Geanetta: During my high school years, I excelled in science—so much so, a teacher recommended me for a paid internship at Chesterfield General Hospital in Cheraw, S.C. After the internship, I was hired by the business office to register patients in the emergency room (ER). Over time the job evolved into other positions. I eventually worked for a physician, Dr. Darlington Hart, who encouraged me to learn more. Then, I moved to Georgia and worked for a great group of internists and rheumatologists at Summit Internal Medicine. The administrator at this group suggested I work in the billing department. I have been immersed in the profession since that time. I now teach medical billing and coding at Southeastern Institute in Charlotte, N.C. I also own and operate with my husband, Charles, CGS Billing Service, coding remotely for medical providers.

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

Geanetta: I have not held a position in the local chapter; however, I certainly encourage others to attend the Monroe, N.C. chapter. My students attend the monthly chapter meetings with me. Some of the students drive at least an hour to attend the meetings. I am proud to say that even after graduation they continue to be involved. Some members who I introduced to the chapter meetings currently hold positions—I'm proud of that.

What AAPC benefits do you like the most?

Geanetta: I enjoy the discount shopping privileges we have. I also enjoy reading *Coding Edge*. I look forward to reading about the variety of specialties. I am comforted because I belong to an organization who keeps my knowledge of coding as their first priority—that's a huge benefit.

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

Geanetta: At times physicians do not understand our importance. Some physicians do not value their coders and feel that it's a job anyone can do. That's simply not true. Great coders can keep an office running smoothly financially. You can teach people to code but AAPC coders care when, what, and how they code. AAPC coders like me strive to do quality work—not just code anything to get a check from the payer.

CE: How are you preparing for ICD-10?

Geanetta: Southeastern Institute will be providing ICD-10 training for all medical billing and coding instructors. We also will phase ICD-10 training into our medical billing and coding program in 2011.

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

Geanetta: I would absolutely love to teach Spanish or history.

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

Geanetta: I spend every free moment with my husband and son. We all enjoy animals and love going to the zoo and aquariums together. I adore my husband because he reads the Bible to me. That's something I cherish because it makes me feel cared for spiritually.

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